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The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY

January 1975, Vol. 36, No. 1

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: The Epidemiologic Transition in North Carolina During the Last 50 to 90 Years: I. The Mortality Transition, Abdel R. Omran, M.D., Dr. P.H.; Utilization of Obstetrical and Neonatal Facilities in North Carolina, Edward H. Bishop, M.D., and George W. Brumley, M.D.; Ethos and Ethics in Medical Education, Larry R. Churchill, Ph.D.

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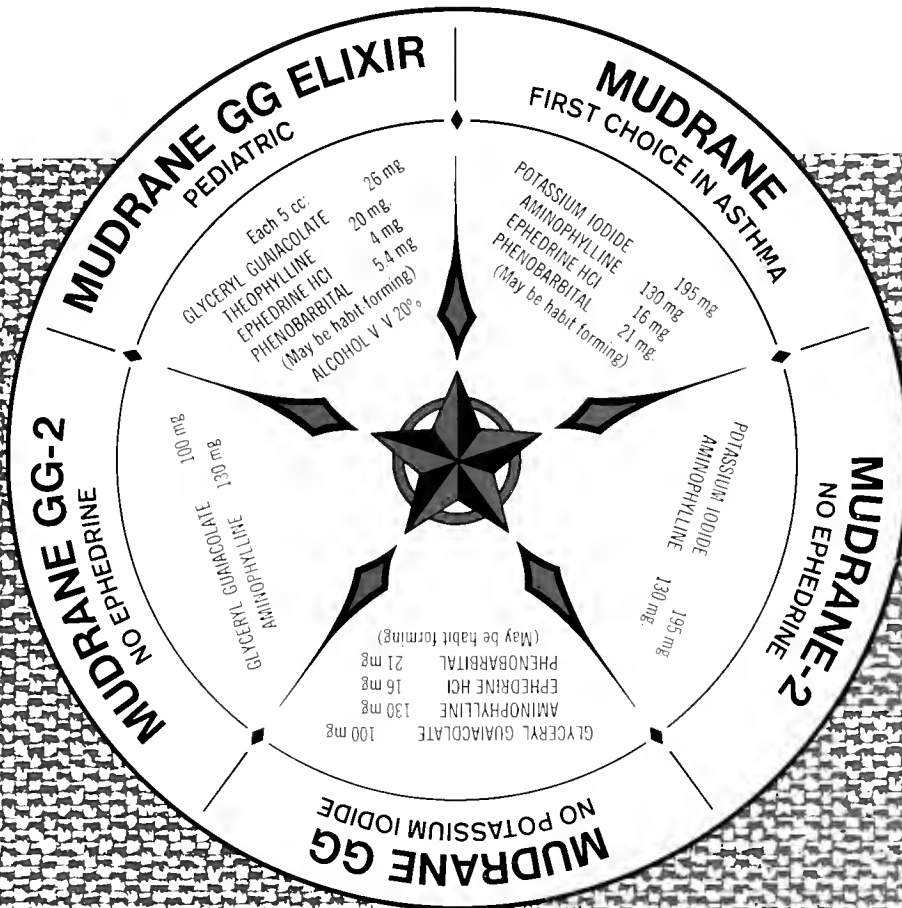
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The Epidemiologic Transition in North Carolina

During the Last 50 to 90 Years:

I. The Mortality Transition

Abdel R. Omran, M.D., Dr. P.H.*

THEORY OF EPIDEMIOLOGIC TRANSITION

A COMPREHENSIVE epidemiologic analysis of population change in various cultural settings was published four years ago as the theory of epidemiologic transition.¹ Conceptually, the theory focuses on the complex changes in patterns of health and disease and on the interactions between these patterns and their demographic, economic and sociologic determinants and consequences. During the transition, the devastating epidemics of specific diseases, famine, endemic infection and chronic malnutrition recede; whereas degenerative and man-made diseases gradually increase.

Three stages in the disease transition are recognized: Stage I is the Age of Pestilence and Famine that characterizes preindustrial societies; Stage II, the Age of Receding Pandemics, accompanies social and economic development; and Stage III, the Age of Degenerative and Man-Made Diseases, characterizes modern, developed societies. During Stage II, the recession in mortality from infection and undernutrition is

striking, and overall mortality declines drastically. Similarly, because of the shift in the age at death—from childhood and young adulthood to older ages—a shift dictated by the prevailing disease pattern, life expectancy increases significantly. Typically, the great improvements in survival which occur with the recession of pandemics are particularly beneficial to children of both sexes and to females in the para-adolescent and reproductive periods. The influence of these mortality changes on fertility movement and on the age and sex structure of the population is described in an earlier publication.¹ Also described are three models of the transition that evolve in different social, economic and biologic settings, namely (a) the classical model which occurred in Western countries and was predominantly socially determined; (b) the accelerated model, which was also socially determined but in which induced abortion played a deciding role in the natality transition, as in Japan, for example; and (c) the delayed model which has been occurring in the less developed countries, where mortality has started to decline dramatically while fertility decline has been considerably delayed. Unlike the classical model, mortality decline in the de-

veloping countries has been predominantly influenced by modern medical technology, usually imported.

TRANSITION IN NORTH CAROLINA

The epidemiologic transition in North Carolina belongs to the classical model. Long-term data on mortality and fertility for North Carolina are lacking; apparently, however, when vital rates were first registered in North Carolina in 1914, the transition was already underway (Figure 1), and the epidemics of infection and undernutrition were receding (and must have been doing so for many decades). Even if the less reliable data for the period from 1880-1914 are included, the available data will not describe the full three-stage transition but only the later phase of Stage II (the Age of Receding Pandemics) and the beginning of Stage III (the Age of Degenerative and Man-Made Diseases). To describe the missing stage (the Age of Pestilence and Famine) would require adequate reconstructed data that are not yet available. It can be assumed, however, that this early stage must have occurred in some form in the seventeenth, eighteenth, and early nineteenth centuries, both in North Carolina and in the countries from

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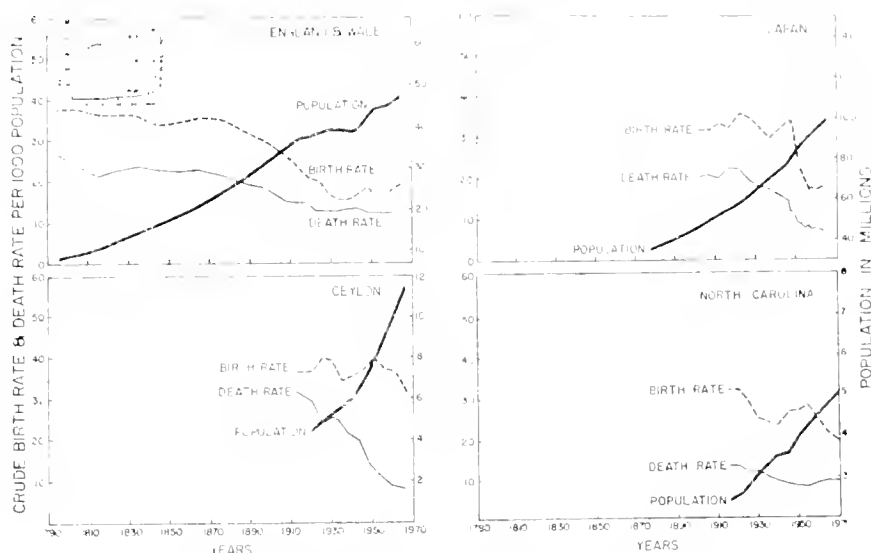


Fig. 1. Demographic trends in selected countries.

Sources: Abdel R. Omran, "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change," *Milbank Memorial Fund Quarterly*, Vol. 49 (1971), p. 515. North Carolina data are from N. C. State Board of Health, *North Carolina Vital Statistics Reports*; U. S. Department of Commerce, *U. S. Vital Statistics, 1920-1960*; and U. S. Department of Commerce, *Census of the United States, 1880-1970*.

which the settlers came. This paper concentrates on the more recent periods for which vital statistics are more readily available.²⁻⁶ Earlier data since 1880 are used only occasionally, and with caution, since such data are less reliable.*

TRANSITION IN SELECTED GENERAL MORTALITY INDICES

In addition to the crude death rate, four other mortality indices have been selected to demonstrate the magnitude of change over time: the crude and adjusted death rates, the infant mortality rate, proportional mortality for certain age groups, and the maternal mortality rate. Because of the wide coverage of this brief presentation, I have included only major trends.

Crude and adjusted death rates

Early estimates of the crude death rate in North Carolina for the latter part of the nineteenth century and

the first decade of the twentieth century provide rates of 15.4 deaths per thousand population in 1880, 11.1 in 1900, and 18.6 in 1910. These data are probably incomplete, and the rates seem to be somewhat lower than would be expected from the prevailing social, biological and medical situation, especially in the nineteenth century. When vital rates were first officially recorded in 1914, the crude death rate was 12.0 per thousand population. In 1915 and 1916, the rates were 12.7 and 12.5, respectively. The rates given in another series, although still low, are more reliable.⁷

During the influenza epidemic of 1917 and 1918, the rate rose to 13.3 and 16.8, respectively, then declined to 12.2 in 1919 and 12.6 in 1920. Since then, the death rate has been declining gradually, reaching its lowest level of 7.4 in 1954, after which it rose slightly and was maintained at between 8.0 and 8.9. The latest 1971 figures indicate a death rate of 8.7 per thousand population.

The trends in the crude and age-adjusted death rates by race and sex are given in Table 1. The crude rates show that the non-white male had the highest mortality risk, followed by the non-white female and the white male, whereas the white female consistently enjoyed the lowest risk of mortality.

When the rates are adjusted for age (using the U. S. population in 1940), a similar pattern by race and sex emerges, but the levels of mortality are higher than the crude rates for the period 1920-1950. In the 1950s, the adjusted rate becomes lower than the reported rates. (This phenomenon is delayed until 1960 for the white male.)

Proportional mortality under five years of age

The proportion of deaths in children under five years of age as a percentage of total deaths is a valuable index for measuring the magnitude of mortality and changes therein over time. It also gives an indication of the prevailing diseases. In North Carolina in 1880, when in-

Table 1
Crude and Age Adjusted Death Rates (Using U.S. Population, 1940) By Race and Sex North Carolina 1880-1970

Year	Crude Death Rate				Adjusted Death Rate			
	Males	White Females	Nonwhite Males	Nonwhite Females	Males	White Females	Nonwhite Males	Nonwhite Females
1880	14.04	13.82	17.33	17.64	14.12	14.31	14.77	16.08
1900	10.19	10.56	12.71	11.92	11.68	12.05	12.22	11.95
1920	12.75	11.07	15.90	16.03	18.83	13.43	16.39	17.58
1930	10.37	8.95	15.39	14.76	13.40	12.04	17.85	17.23
1940	8.95	6.88	12.56	10.77	11.63	9.03	14.23	11.79
1950	8.04	5.62	10.88	9.09	9.42	6.28	11.35	8.96
1960	9.27	6.27	11.62	8.80	9.64	5.58	11.40	7.63
1970	9.88	6.81	12.33	8.51	9.60	5.09	11.62	6.52

Sources: 1880 data are from U.S. Department of Commerce, *Census of the United States, 1880*; data for 1920-1960 are from: U.S. Department of Commerce, *U.S. Vital Statistics, 1920-1960*; Forrest E. Linder and Robert D. Grove, *Vital Statistics Rates in the United States, 1900-1940* (U.S. Government Printing Office, 1943); and Robert D. Grove and Alice M. Hetzel, *Vital Statistics Rates in the United States, 1940-1960* (U.S. Government Printing Office, 1968); and 1970 data are from North Carolina State Board of Health, *North Carolina Vital Statistics, 1970*.

* Decennial census material from 1880, 1890, 1900, and 1910 does not provide information about vital statistics for North Carolina. Such data are available beginning in 1917 when the State of North Carolina became part of the national vital statistics registration area.

* Another series gives higher estimates for the decade 1910-1920 as follows:
1910 18.62 1913 16.54 1916 12.91 1919 12.18
1911 18.27 1914 18.96 1917 13.78 1920 12.67
1912 17.10 1915 17.29 1918 12.14

tious diseases and undernutrition are still dominating the health scene, the mortality toll among children was extremely high (Figure 2a). Of all deaths in that year, 45.7 percent occurred among children under five years of age. The comparable figures were 41.8 percent for white children and 50.8 percent for non-white children. Disproportionately high mortality in this age group is due to the vulnerability of very young to infectious and deficiency diseases. With the recession of these diseases, especially in the twentieth century, proportional mortality in this age group declined steadily. In 1970, the index was 4.7 percent for both races, with 4.7 percent for white children and 9.5 percent for non-white children.

Proportional mortality 50 years and over

This index is a sensitive and comprehensive mortality indicator which relates deaths occurring at age 50 years and over as a percentage of total deaths. As might be expected, proportional mortality, as shown in Figure 2b, rises with health improvement and recession of infectious and deficiency diseases which leads to increased life expectancy, since proportionately more people survive until age 50 and will die thereafter. For all races, the index rose from 21.1 percent in 1880 to 46.6 percent in 1920 and to 77.3 percent in 1970. The levels of this index are higher for whites than for non-whites, and for females than for males (not shown in figure).

Infant mortality rate

Infant mortality has shown a substantial decline during the past 58 years. When it was first registered in 1914, the rate was 90.3 deaths per thousand live births. After peaks of 99.6 in 1917 and 101.8 in 1918 (the years of the influenza epidemic), the rate showed a trend of slow decline with occasional upward fluctuations until the early 1940s when substantial decline occurred, followed by leveling in the late 1940s and the 1950s. Further small declines occurred in the 1960s, and in 1970 the infant mortality rate

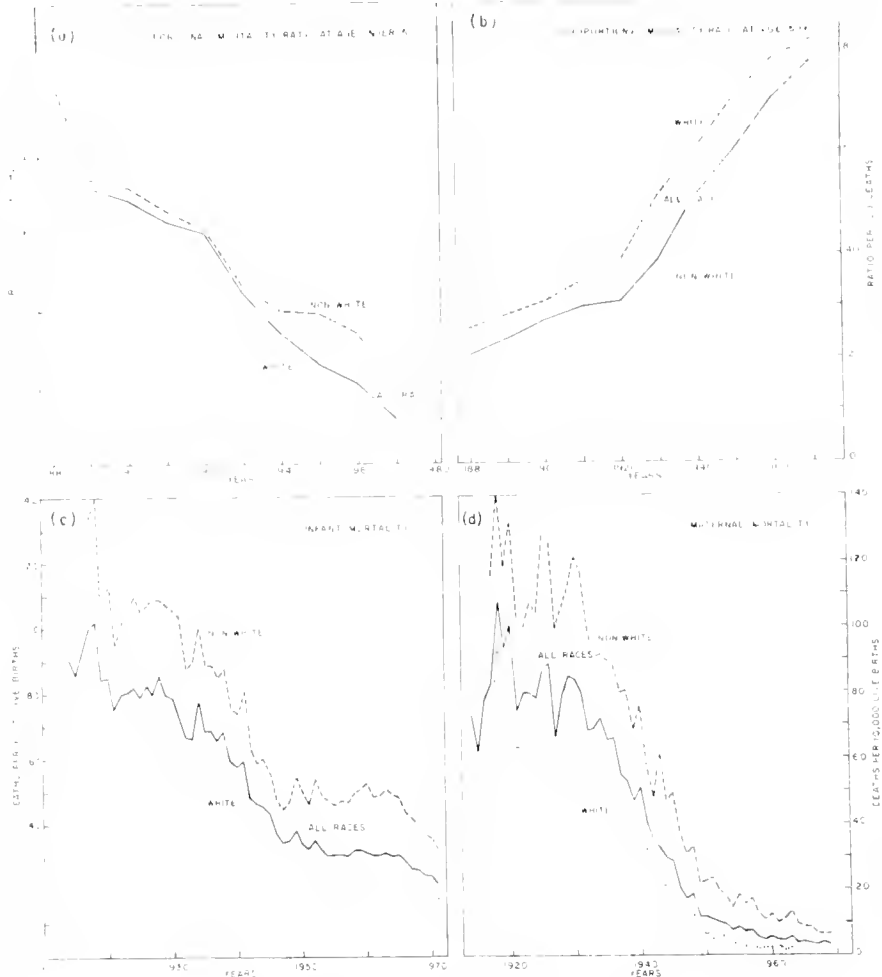


Fig. 2. Mortality profiles in North Carolina.

Sources: U. S. Department of Commerce, *Census of the United States, 1880-1970*; Forrest E. Linder and Robert D. Grove, *Vital Statistics Rates in the United States, 1900-1940* (U. S. Government Printing Office, 1943); Robert D. Grove and Alice M. Hetzel, *Vital Statistics Rates in the United States, 1940-1960* (U. S. Government Printing Office, 1968); 1970 data are from *North Carolina Vital Statistics, 1970*.

was down to 24.1 per thousand live births. Throughout this period, non-white infants sustained higher risk of death; for example, the peak mortality in 1917 and 1918 was 133.1 and 139.5, respectively, for non-white infants as compared to 84.8 in both years for white infants. In 1970, the rate for non-white infants was still higher than that for whites, 35.8 deaths per thousand live births as compared to only 19.2.

Maternal mortality

During the periods of social and health improvements, maternal mortality declined continually, as demonstrated by Figure 2d. The non-white maternal mortality rate dropped significantly from a peak

of 139 per thousand births in 1918 to 6.6 in 1969. Similarly, the rate for white women decreased from 94 to 1.8 during the same period. The trend lines noticeably show relatively violent fluctuations, especially before 1930, illustrating the sensitivity of this index to changes in mortality patterns.

TRANSITION IN DIFFERENTIAL MORTALITY BY AGE, SEX, AND RACE

A central proposition of the epidemiologic transition theory states that the most profound changes in health and disease patterns during the transition take place among children and young women.² This is true for North Carolina, even within

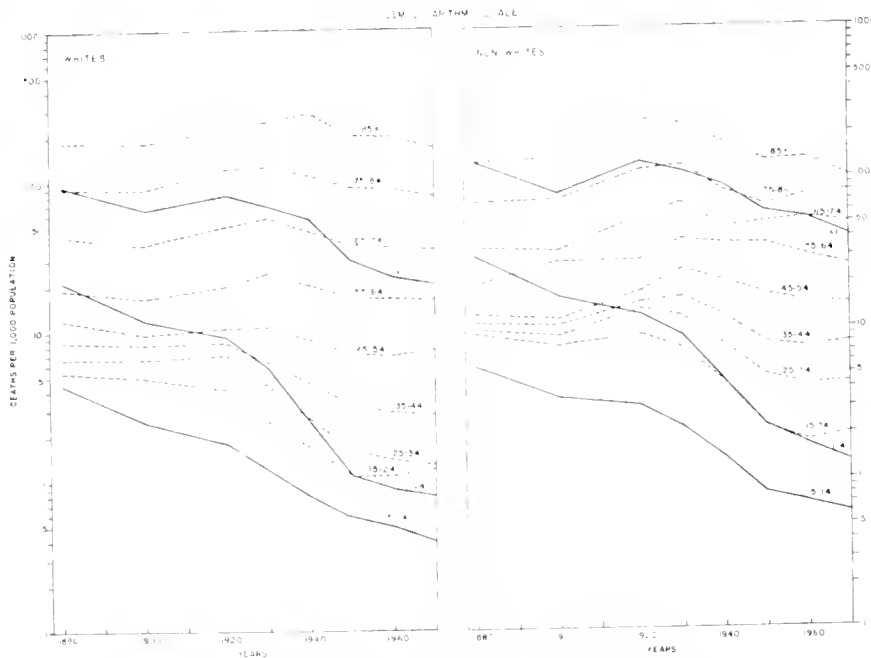


Fig. 3. Trends in age-specific death rate in North Carolina.

Sources: 1880 data are from U. S. Department of Commerce, *Census of the United States, 1880*; data for 1920-1960 are from: U. S. Department of Commerce, *U. S. Vital Statistics, 1920-1960*; Forrest E. Linder and Robert D. Grove, *Vital Statistics Rates in the United States, 1900-1940* (U. S. Government Printing Office, 1945); and Robert D. Grove and Alice M. Hetzel, *Vital Statistics Rates in the United States, 1940-1960* (U. S. Government Printing Office, 1968); and 1970 data are from *North Carolina Vital Statistics, 1970*.

the relatively short period of time under consideration, which covers Stages II and III of the transition.

Age-specific death rate

A series of age-specific death rates since 1880 is available, but the data since 1915 are more reliable. Hence, the apparent increase in the death rate in certain age groups between 1880 and 1920 (Figure 3) may be due to better reporting. In general, however, the greatest mortality decline occurred in the younger age groups including the groups under one year, one to four years, and five to 14 years of age. This tendency holds true for both whites and non-whites and may have great impact on the age structure of the population. The improvement in childhood survival results in waves of young members moving up the population pyramid, causing a younger age structure for the whole population. Improved fertility performance (due probably to better survival chances for females, de-

creased widowhood and decline of disease affecting fertility) also contributes to a younger age structure. This cycle continues until fertility is drastically controlled and the supply

of children decreases. With increased life expectancy, the top of the pyramid widens.*

One other way of demonstrating the magnitude of mortality improvement in childhood is to examine the proportionate contribution of each age group to the total mortality decline. A standard population of one million with the age distribution of the United States in 1940 was used to calculate the standardized mortality decline by age between 1880 and 1970 and between 1920 and 1970. The results of this exercise are given in Table 2. Between 1880 and 1970, mortality decline among children under five years of age was responsible for 39.3 percent of the total mortality decline in all ages, while mortality decline among those under 15 years of age was responsible for 50.1 percent of the total decline. The corresponding figures for the decline between 1920 and 1970 are 23.3 percent and 27.4 percent, respectively.

Age and sex-specific death rates

The age and sex-specific death rates were plotted on a semilogarithmic scale for whites and non-whites (Figure 4). It is striking that in 1880, when the leading causes of death were infectious diseases and

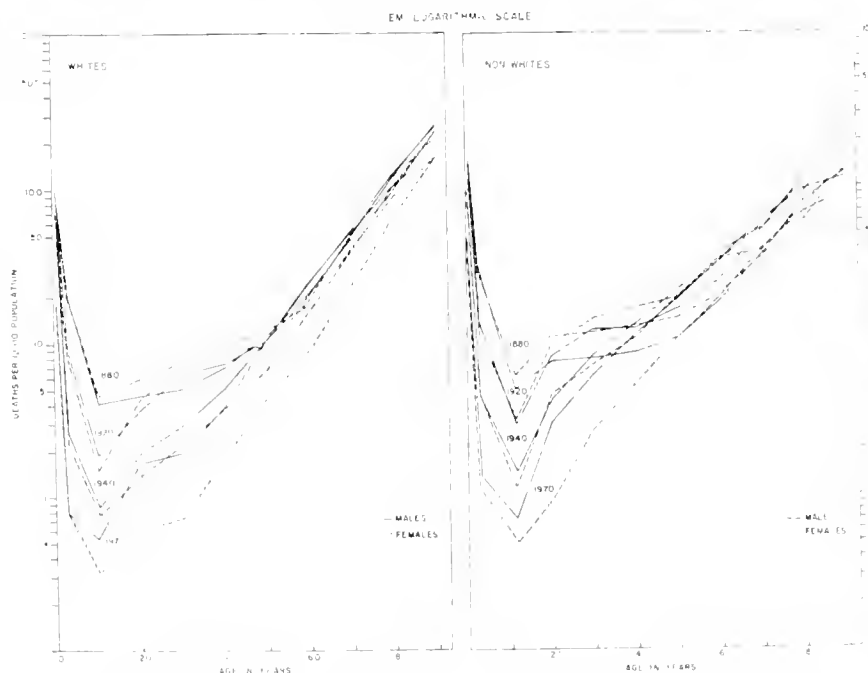


Fig. 4. Trends in age and sex profiles of mortality in North Carolina.

Sources: Same as Table 1.

* In North Carolina, however, attention should be given to the migration patterns in different periods of time, which affect the composition of the population.

higher for whites than for non-whites of both sexes, and better for females than for males of both races in every year under examination except 1925, when the non-white female had eight months less life expectancy at birth than the non-white male. Survival considerably improved between 1925 and 1960 for both races. For example, by 1960 the expectation of life at birth was 67.0 years for white males, 74.9 years for white females, 59.2 for non-white males and 65.6 for non-white females.

The gains in life expectancy are not homogeneous at different ages. Most of the years gained have been in childhood and young adulthood, due to the substantial decline in mortality in these age groups. Gains in life expectancy have decreased almost steadily with advancing age. It is also important to note that the years gained in life expectancy were greater for females than for males in each race and greater for the non-

white population of both sexes than for the white.

Finally, the life expectancy ranking of North Carolinians as compared with the other states might be considered. In 1959-1961, North Carolinians placed as follows: life expectancy for both races and sexes ranked forty-third in the country; for white males, life expectancy ranked thirty-eighth, and for white females, eighteenth.

SUMMARY

In this paper the theory of epidemiologic transition has been briefly outlined. Certain principles of the theory have been applied to North Carolina during the last 50 to 90 years, using available data to discover the effects of the transition as revealed by selected general mortality indices, by differential mortality by age, sex and race, and by life table functions.

ACKNOWLEDGMENTS

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During the reign of Louis Philippe, a Danish physician professed to cure, or at least to check, attacks of asthma by cauterizing the pharynx with ammonia. He had acquired a considerable reputation, and the King's sister wished to submit herself to his treatment. It happened, however, that a maid of honour, who was asthmatic herself, died suddenly at the moment the physician touched her pharynx with the ammonia. From that time there was no more talk of the Danish physician or of his wonderful cures.—*Death and Sudden Death*, P. Brouardel, 1987, pp. 22-23.



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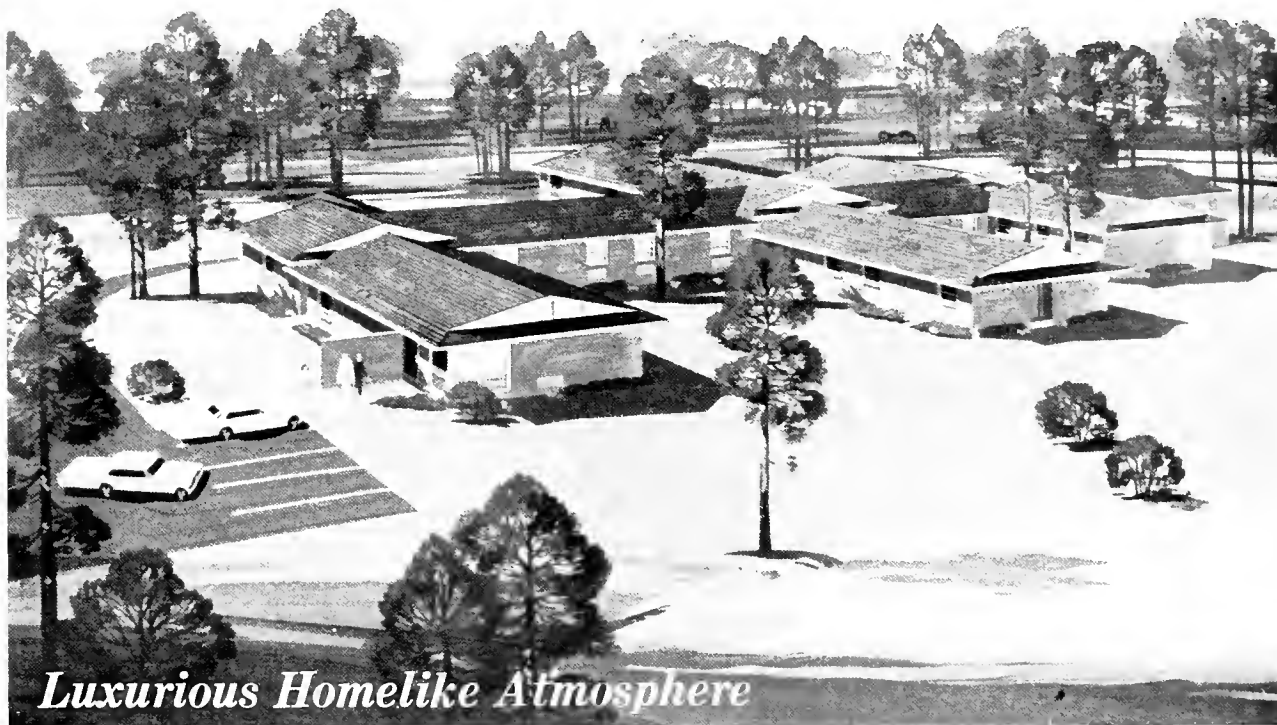
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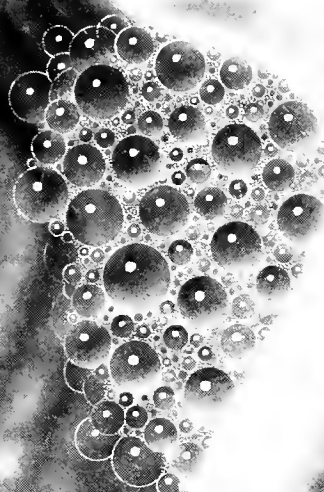
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Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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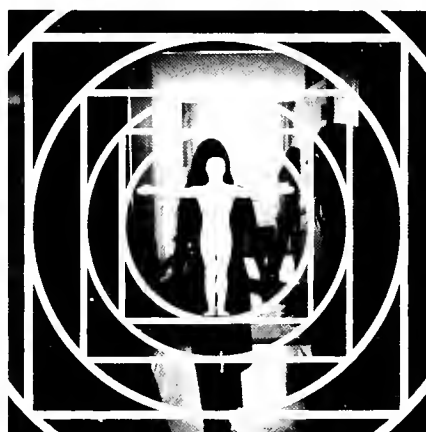


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Ragan, C. The Clinical Picture of Rheumatoid Arthritis. in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335

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Indications Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications Children 14 years or less, senile patients, history or symptoms of GI inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension, thyroid disease, systemic edema, stomatitis and salivary gland enlargement due to the drug, polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings Age, weight, dosage, duration of therapy, existence of concomitant diseases and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and GI tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult GI bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

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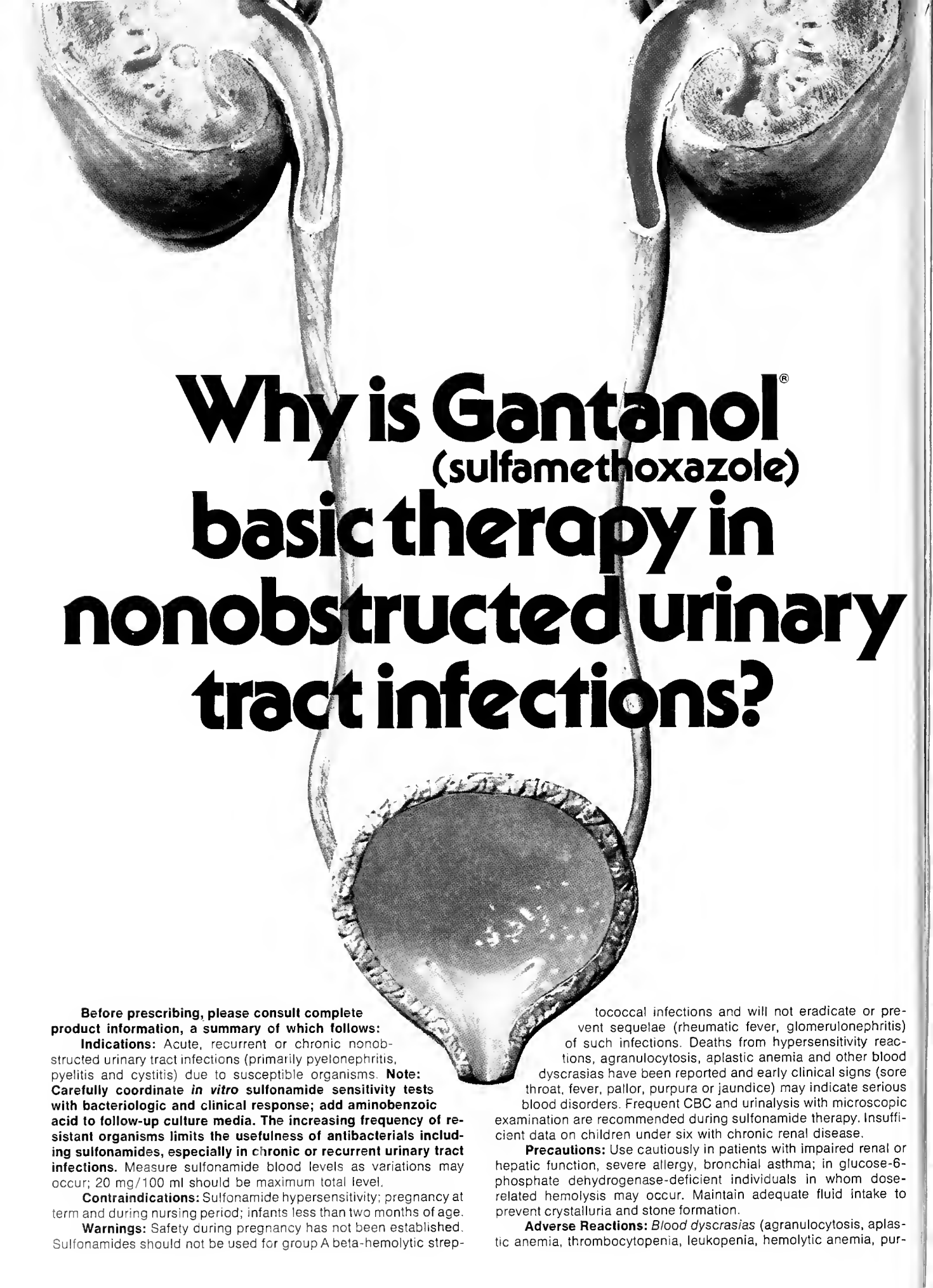


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Utilization of Obstetrical and Neonatal Facilities in North Carolina

Edward H. Bishop, M.D.* and George W. Brumley, M.D.†

A NATIONWIDE inflation associated with increased costs of both personnel and equipment has resulted in a seemingly endless escalation of hospital costs during the past two decades. Other than an alteration in the national economy, the only apparent method of reducing medical costs, under these circumstances, is by improving efficiency in the utilization of both physical facilities and manpower.

A review of the current (1972) utilization rates of obstetrical and neonatal facilities was one of the objectives of a hospital survey undertaken by the Task Force on Maternal and Infant Care. Questionnaires were sent to 125 hospitals in North Carolina and answers were received from 102, or 82 percent of the hospitals reporting maintenance of obstetrical and neonatal services. These responses represented 81,788 births, or 92 percent of the births in North Carolina during 1972. *Standards for Obstetrical and Gynecolo-*

gical Services, a manual published by the American College of Obstetricians and Gynecologists states that "there should be one delivery room for each 500 deliveries if fewer than 1,000 women are delivered each year. On larger services, for example, four delivery rooms would be quite adequate for 3,000 deliveries."¹ From this statement we may

extrapolate that an efficient utilization rate for a delivery room (and the associated personnel) would be 750 deliveries per year or approximately two per day. Among the 102 hospitals reviewed in this survey, 208 delivery rooms were utilized for 81,788 births or 1.1 births per delivery room per day — an extravagance that is not only inconsistent

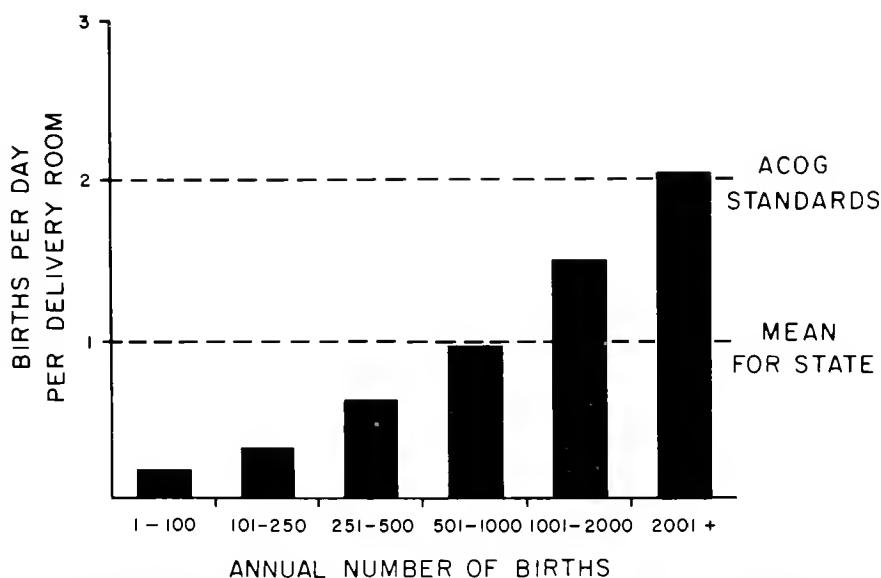


Fig. 1. Number of births per delivery room per day by size of obstetrical service.

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Reprint requests to Dr. Bishop.

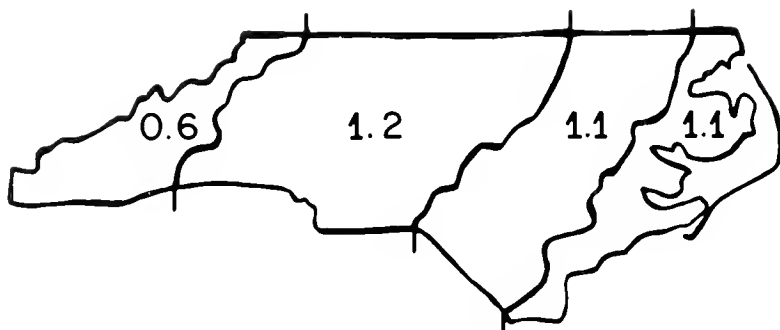


Fig. 2. Number of births per delivery room per day by geographic area. State average 1.1.

with effective medical care but, more importantly, is also unsound economics.

The number of births per delivery room per day, controlled by the annual number of births, is illustrated in Figure 1. In those hospitals reporting fewer than 1,000 births annually, delivery room facilities remained idle and unused for a vast portion of each day. Only those hospitals reporting more than 1,001 annual births attained a utilization rate of delivery rooms exceeding the average for the entire state. Only those reporting 2,001 or more births attained a utilization rate consistent with the recommendations of the American College of Obstetricians and Gynecologists.

The low utilization rates of the smaller hospitals may be a reflection of the sparse distribution of the population within the area served. In order to confirm this impression in greater detail, the state was arbitrarily divided into four areas based on geographic and economic differences as described by *The Atlas of North Carolina*.² These areas are represented in Figure 2 which gives the utilization rate of delivery room facilities for each geographic area. Only in the Piedmont area did the utilization of delivery room facilities approach ideal levels. The lowest utilization rates were reported by the hospitals in the western area of the state. This deficiency offers further evidence of the existence of an excessive number of small hospitals with a decreased chance of economical operation.

Similar standards have been formulated for evaluating the utilization of maternity beds and nursery fa-

cilities.³ The American College of Obstetricians and Gynecologists has suggested that, based on an average four-day postpartum stay, a 70 percent occupancy rate of these facilities would be reasonable. Therefore, each obstetrical bed should be utilized by approximately 60 patients per year. This ideal occupancy rate may be unrealistic since idle maternity beds may often be used for other purposes when the obstetrical census is low. Nevertheless, it is safe to conclude that in view of the present birth rate in North Carolina, an excessive number of hospital beds is assigned to obstetrical services. This situation is particularly true of the smaller services, but no group of hospitals approached the suggested standards.

Care of the premature infant and management of other neonatal problems result in an average seven-day stay for the newborn infant. Therefore, based on an ideal 70 percent occupancy rate, each nursery bassinets should be utilized by approximately 36 infants per year. Actual utilization rates of both maternity beds and bassinets, controlled by the size of the obstetrical service (annual number of births), are given in Table I. Nursery bassinets are not ordinarily used for purposes other than the care of the newborn and, therefore, particularly in those hospitals with the smaller obstetrical services, an excessive number exists. Amalgamation of those hospital services which are in close geographical approximation may be a possible solution to this problem. Occupancy rates of maternity beds and nursery bassinets for each geographic area of the state are illustrated in Table

2. No area of the state achieves those ideal rates considered to be good economic practice. As previously mentioned, the western portion of the state reported the lowest occupancy rates of the four geographic areas, probably because this area includes the highest proportion of hospitals with small obstetrical and newborn services. Neither the state as a whole nor any area of the state achieved those levels of occupancy usually accepted as efficient standards.

Table 1
Occupancy Rates of Maternity Beds and Bassinets
By Annual Number of Births

Number of Births	Occupancy Rates (Percent)	
	Maternity Beds	Bassinets
1 to 100	15	13
101 to 250	35	26
251 to 500	37	45
501 to 1,000	44	52
1,000 to 2,000	51	80
2,001 +	59	84
All hospitals	48	61

Table 2
Occupancy of Maternity Beds and Bassinets by Geographic Area

Geographic Area	Occupancy Rates (Percent)	
	Maternity Beds	Bassinets
Mountain	39	44
Piedmont	49	65
Coastal plain	48	61
Ocean	47	61
North Carolina	47	61

The data obtained from this survey indicate that North Carolina has many poorly utilized obstetrical and neonatal services. It would appear that in many areas the number could, and probably should, be reduced. This survey reviewed only the quantity of obstetrical and newborn services; no conclusions from these data can be reached regarding either maldistribution or quality. Undoubtedly, amalgamation of many of these hospital services could be accomplished with a resultant increased efficiency of operation and decreased cost of medical care.

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Ethos and Ethics in Medical Education

Larry R. Churchill, Ph.D.

PROFESSIONAL work of any sort tends to narrow the mind, to limit the point of view, and to put a hallmark on a man of a most unmistakable kind.¹

A humanist undertaking a study of the value dimension in medical education meets with a wide variety of responses. After explaining the purpose of my study to a third year medical student he replied, "There's no time to learn values here; what we have to learn is how to be competent physicians. The old family doctor was great with his patients, but let's face it—he simply didn't know any medicine."

Such a response—not universal, yet not atypical—is itself a commentary upon the value transmission in medical education. Nevertheless, it is a widely held opinion that the learning of values is accomplished in formal course work (or, alternatively, from one's parents in early childhood) when the focus is upon "ethics" in the same manner in which one might study Romantic poets, or gross anatomy. It could be argued that such an opinion finds its source, philosophically, in the rise of modern scientific thought in the seventeenth century and in the epistemology of Rene Descartes, i.e., in the depersonalization of knowledge, the distrust and alienation of the senses from the noetic situation, and the elevation of mathematics as

the model for a precise tool of inquiry. I do not wish to argue that historical case here. I do wish to suggest that, despite the predilection to consider facts and knowledge as totally distinct from values, the experiences in medical education constitute a workshop for values. Medical sociologists have been aware of this for some time, yet this insight has not been systematically cashed out in terms of the philosophy of medicine and especially not in terms of all that falls under the rubric "medical ethics."

It will be useful initially to distinguish between an *ethical system*, composed of explicitly held rules, formulae, and moral principles, and a nexus of *ethological norms* or *values*.² Ethological values are quite often loosely identified, seldom find articulate form, and generally operate inconspicuously in the routines of a given community. An ethos is the characteristic spirit, the prevalent tone of sentiment, or the special genius of a community. Etymologically there is a common root for the terms "ethos" and "ethic," suggesting a normative dimension to an ethos and the germination of a specific, formalized ethic out of the character of the community and its subcultures. I wish to suggest that it will be important to ethologically view the medical community and its various subcultures of specialties and to inquire into its moral and intellectual norms. The ethological norms of the medical community are

not the sole determinants of the physician's sense of care, responsibility and the ethics of practice, but they are very powerful unexplored determinants.

These ethological norms are held *tacitly* by practicing physicians, and they are reinforced by the sociological shapes of medical work. For example, the expectations for physician-patient relationships, on the part of both physicians and patients, are so strongly grounded in custom and so widely accepted that they seem "natural" or self-evidently "right." Therefore, the value dimensions of any given physician-patient interaction usually can be read off the requirements of the social situation; that is, the notion of what is and is not within the sphere of the physician's responsibility, or what constitutes appropriate conduct, is already understood and unreflectively endorsed. Hence, the power that ethological norms hold over the actions of any community is at least partially derived from the tacit status such norms occupy within the work of that community.

In medical education these norms are transmitted largely (and most powerfully) through the characteristic forms of practice, as these are in-dwelled by apprenticeship of the student-physician; that is, they are transmitted largely through the models, metaphors, and paradigms which inform the routine practices of physicians. In this way, teaching physicians know and teach more

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than they can explicitly say. The value dimensions of the medical ethos cannot be taught, for the same reasons that virtue cannot be taught, but they can be shown. That of which the teaching physician cannot exhaustively speak, he bespeaks through the character of his actions. The informal, unarticulated role manifestations, the professional modeling unassumingly performed by attending physicians and senior house staff, is far more powerful in transmitting values and attitudes to medical students than any of the formal, explicit desiderata of their teaching.

Together these ethological norms make up the professional self-image with its attendant expectations and preoccupations. This phenomenon can be sociologically referred to as a study of the "role" of the physician and the learning of this role by the student-physician. The burden of my thesis is that "role" is both a descriptive and a normative term, and furthermore that the normative dimensions of a role are often deep-seated tacit components in the formulation of surface, explicitly ethical questions.

I suggest that not all the important norms of the medical ethos are presently identified (or even identifiable) and that few, if any, have been explored systematically. For example, little work has been done on the perceptual, epistemic and linguistic norms which make up the sensibility of physicians. One norm which is well identified and which relates ubiquitously to patient care is variously termed "detached concern,"³ "disinterested sympathy,"⁴ "empathy and affective neutrality,"⁵ and other terms which suggest a balance between the distance necessary for professional competency and the concern which lies at the heart of patient care. This complex norm is particularly important because it relates to the widest possible range of physician-patient relationships. Indeed, it gives shape to the whole spectrum of physician-patient contacts. An inquiry into its nature, as it operates ubiquitously in the training of medical students, could serve as a point of entry into the pro-

fessional self-image generally, and into the characteristic ways in which the medical ethos schools its initiates to view man, the human body, care and responsibility. Hence, an inquiry into this norm and its ethological habitat is an important place to begin an inquiry into medical ethics.

All the phrases mentioned previously to describe this norm conjoin two distinct sets of ideas:

detached: unfastened, separated, disengaged, disconnected

disinterested: impartiality, unbiased as to the possibilities

affective neutrality: emotionally (as opposed to cognitively) uncommitted, having unbiased feelings

concern: to have a share, interest or part with

sympathy: sameness of feelings, not necessarily implying approval

empathy: sympathy, but with a retension of awareness of the other

I suggest that the reason many physicians function comfortably and effectively within this norm is that they have found it to be workable and valuable in terms of the routine performance of their tasks. Indeed, it is primarily because of its wide acceptance and endorsement by physicians that it deserves serious critical attention. Additionally, it seems that the complex nature of this attitudinal norm makes it susceptible to misunderstanding. Hence, in what follows I shall tentatively explore what it predisposes student-physicians to think about themselves conceptually and how it predisposes them to act practically.

On the conceptual level, this two-faceted norm predisposes the student-physician to a fragmentation that divides his knowledge (*qua* cognition) and his attitudes (affective dimensions); it completely dissociates the latter from the skilled utilization of the former. A typical division in the articulation of the aims of medical education specifies knowledge, attitudes and skills. Although this division is theoretically

useful, it easily lends itself to a formal reification which ignores the interplay of all these factors in the most modest and routine physician-patient interchange. Yet fragmentation is only the first stage in the process of achieving a true dualism, which occurs when the fragmented elements of a person's sensibility are acknowledged to be divorced into two antithetical clusters, and when this dichotomy constitutes a standard for practice.

In summary, the more fundamental difficulty involved with this complex norm is that it predisposes the student-physician to a paradigmatic division between his competence and effectiveness as a physician and the affective dimensions of his skills. The physician operates most effectively when he dissociates his cognitive content and his affective acuity — so this high paradigm suggests. To be sure, the model obligates the physician to establish rapport, trust and an affective relationship with his patients. The central point of my critique is that this level of affectivity between physician and patient is usually conceived to have a totally external relation to the physician's knowledge, or to the skilled utilization of such knowledge. A resident once admitted that he treats patients callously on morning ward rounds, but he quickly added that a member of the ward team goes back to see these patients later in the day and then they are treated differently. It follows that this physician, who has achieved the paradigmatic disaffiliation in his work, should be admired as one admires a performer who achieves difficult feats with one hand behind him.

Yet the thesis discussed here — that the complex ethological norm easily lends itself to a conceptual dualism — would be insignificant without a recognition that conceptual presuppositions often find practical predispositions. A visiting professor of pediatrics, addressing the house staff on infant resuscitation, asked who among them would inject an alkaline solution after five minutes of lack of spontaneous breathing and heartbeat. After a brief pause, roughly half raised their

hands in assent. When the professor asked why, a resident answered in terms of the balance of body chemistry and muscle stimulation. The professor then asked this resident whether he knew that the chances of substantial, irreversible damage after five minutes were great, and that the divorce rate after one year for parents of such children in a major United States city is approximately 50 percent. Whether the resident was actually aware of these statistics is important; yet more fundamental is the fact that a question which is *prima facie* answerable on strictly pathophysiological grounds requires an answer on ethical grounds. What deserves attention here is the degree to which the interpersonal and social dimensions of medicine can become habitually secondary, even tertiary—not out of conscious design, neglect or premeditated ordering of priorities, but because the ethological norms, which give shape to the medical student's training, predispose him to a conceptual dualism and to a practical preoccupation with quantifiable reality. In the practical ordering of a crowded schedule, detachment is easily translatable into total disengagement from the life of the patient. Disinterest easily slips into uninterestedness in the routines of the ward and under the pressures of being assessed on grounds which discredit the nonformalizable facets of professional competence.

A senior medical student spoke in the emergency room of the value of his military experience in preparing him for medical school. Responding to his accounts of medicine on the battle front, I remarked that one must get accustomed to seeing men maimed and dying. "Sure," he replied, "I can eat my lunch off a corpse." It is not my purpose here to explore how medicine teaches its initiates to cope with the phenomenon of death. I want only to note the commonplace: the experiential toll of medical education, as well as the toll in terms of finances and energies, is high. Therefore, affective distancing is a prerequisite. Such experiences as venipuncture, physical examinations, experientia-

tions with animals, and autopsies lengthen this distance and enlarge its domain as a technique of the profession. Even the use of highly specialized technical language can be utilized as an instrument for affectively displacing oneself in order to proceed professionally with the work. Hence, it should not seem surprising that some students feel relief upon being told by a teaching physician that in spite of their idealized image of the physician, "You are really just well-trained, highly paid technicians."

The norm of detachment, distance or disinterest is powerful because it is sociologically functional, psychologically reassuring and epistemologically in accord with the regnant paradigm for any truly scientific undertaking.

"Disinterest," "detachment," and "affective neutrality" are terms used to designate the professional distance necessary for the achievement of therapeutic goals. Such a distance is indispensable. Yet to couch this professional attitude primarily in terms of a discreditation of emotions, feelings and untidy perceptual awareness creates more problems than it solves, since it easily becomes a ubiquitous philosophical commitment divorced from its particular function and specific telos in patient care. This telos is the achievement of diagnostic and therapeutic goals which are patient-specific and grounded in particular concrete problems of care. Detachment becomes debilitating when it becomes a free-floating professional style or an aegis from critical self-examination. Detachment limits the personal (nonprofessional) involvement of physician with patient, protecting both parties, preserving the physician's judgment, but prohibiting him from becoming judgmental toward the patient. Yet the affective dimension is one of the most fecund, and it gives depth and insight into more formalized medical knowledge. Professional detachment can become counterproductive to the extent that it renders impotent the perceptual acuity inherent in the emotional dimensions of understanding and caring for others.

Following this line of reasoning, what the student-physician must learn is not to demonstrate both detachment and concern, or even to balance the two disparate poles of this norm. Rather, the goal is to integrate them as effective tools for medical practice. Such an integrative feat will require space for critical reflection upon the process of medical education by those in training and endorsement of the development of such skills in students by teaching physicians.

One way for the physician to begin to understand and assess medical education, with reference to the student-physician, is to ask what models, paradigms and conceptions of himself are made available to the student-physician through the experiences, frameworks and shapes of interaction which characterize the medical educational process. If the insights of affectivity, the skills of a teleologically-grounded concern, and the diagnostic powers of personal values have been relegated to a secondary status in medicine, it is not because our theory has been inadequate (although it has); it is rather because the ethological commitments of medicine have endorsed this order of priorities through the forms of work and the experiences of training. It follows that the primary (although not the exclusive) impetus for changing or reordering these priorities lies with physicians. But attempting to make a place for the wide range of nonquantifiable dimensions in medical education mentioned previously, altering the conceptual grounds on which such dimensions can be legitimated, is a beginning.

ACKNOWLEDGMENT

I am indebted to Professor Ruel W. Tyson, University of North Carolina at Chapel Hill, for inviting my attention to the ethos of medicine.

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Editorials

SUGGESTIONS FOR AUTHORS

The NORTH CAROLINA MEDICAL JOURNAL welcomes original contributions to its scientific pages, expecting only that they be under review solely by this JOURNAL at a given time, and that they follow a few simple guidelines. The guidelines are as follows:

1. Subject Matter

Educational articles, especially those in which particular applications to the practice of medicine in North Carolina are developed, are one of the main objectives of this JOURNAL.

Articles reporting original work by North Carolina physicians are invited, whether the work is done in a clinic, a laboratory, or both. The editor and his consultants will evaluate the work by the usual criteria, including a proper discussion of previous work, control observations, and statistical tests where indicated.

Historical articles, especially those dealing with local history, are considered of real value and interest.

2. Manuscripts

An original and a carbon copy of the manuscript should be submitted, one for review by the editorial staff, the other by referees. The manuscript should be typed on standard-size paper, double-spaced, with wide margins (one inch on each side).

3. Bibliographic References

References to books and articles should be indicated by consecutive numerals throughout the text and then typed, double-spaced, on a separate page at the end of the manuscript. Books and articles not indicated by numerals in the paper should not be included.

References will be much more valuable to the reader if they are given in a proper form and contain the full information necessary to locate them easily. The NORTH CAROLINA MEDICAL JOURNAL follows the form used in the journals of the American Medical Association and the *Index Medicus*, giving the author's surname and initials, title of the article, name of the periodical, volume, inclusive page numbers, and the date of publication. It is believed that this style makes it easier for the reader to judge whether the reference is likely to prove useful to him, and enables him to locate it more quickly.

4. Tables and Illustrations

Tables and legends for illustrations should be typed on separate sheets of paper. The illustrations should be glossy black-and-white prints or line drawings. It is necessary to obtain permission from the author or publisher to reproduce illustrations which have been published elsewhere. Costs in excess of \$15.00 for illustrations are borne by the author. Costs for setting of tables are also borne by the author as are charges for art work which might be needed for proper printing of figures.

5. Style

The style followed by this JOURNAL will be, in general, that outlined in the Style Book issued by the Scientific Publications Division of the American Medical Association, John H. Talbot, M.D., director. All manuscripts are subject to editorial revision for such matters as spelling, grammar, and the like.

By following the above suggestions, writers will greatly expedite the publication of papers accepted by the NORTH CAROLINA MEDICAL JOURNAL.

GONORRHEA 1974-75

One of the features of American society seems to be our impression that we can achieve absolute victory over any antagonist, whether diplomatic, economic or medical. Witness highly touted campaigns to defeat cancer, to establish total peace and to annex the solar system. While entertaining such star-spangled ambitions, we sometimes neglect the back-yard garden where gonorrhea has always been a hardy perennial. We relied on mercury-based prophylactics, VD lectures, audiovisual aids and moral re-awakening without victory before penicillin appeared as yet another answer. But answers beget more questions, as the most recent recommended therapies for gonorrhea, appearing elsewhere in this issue of the JOURNAL, demonstrate. Since gonorrhea is as prevalent as taxes, we can be unhappily sure that these recommendations can hardly be termed final.

CIGARETTES, WHISKEY AND WILD, WILD WOMEN—DEFICIENCY MANIFESTATIONS?

Hickey et al, writing in JAMA (230:209-210, Oct 14, 1974), propose that some people smoke tobacco and drink coffee because they are deficient in biogenic amines. Because the medical profession has limited means of diagnosing such deficiency and is largely disinterested in either finding or treating it, these folks take their own medicine, or poison, depending on how one looks at it. It surely is an attractive idea. We all know people who just can't seem to rejoin the living in the morning until they have drunk a dose of coffee and smoked a mess of cigarettes to a predetermined individual dose. The coffee break, long considered a concession primarily socially motivated, may really be providing employers with workers who have adjusted their biologic amine concentrations to levels needed for proper function.

With a reasonable basis for the biologic amine deficiency theory existing, can one take the idea further? It has been thought that genetic influences have been important in alcoholism. Alcoholics often act as though they are deficient in alcohol. It has been said that Ernest Hemingway, at one point, considered life unbearable without alcohol. Maybe there are people who need to have their brains depressed by alcohol periodically — or by marijuana or some other drug. Does Evel Knievel need to jump increasingly long strings of trucks to keep his adrenal medulla glistening? Are satyrs and nymphomaniacs really

searching for some genital secretion which they lack? The list is greatly expansible. Almost any vice or crime can be converted into a deficiency state if we can just tie it to the proper physiologic setting. The secularization of judging human behavior is greatly aided by such maneuvers. Maybe it should be. Then again, maybe not.

R.W.P.

Emergency Medical Services



PROPOSED GUIDELINES FOR PEDIATRIC OFFICE EMERGENCY EQUIPMENT

Ralph H. Kunstadter, M.D., Chairman
Committee on Disaster and Emergency Medical Care
American Academy of Pediatrics

The Committee on Disaster and Emergency Medical Care of the American Academy of Pediatrics and the Chairman of the American Academy of Pediatrics Committee on Accident Prevention, the liaison member from the American Academy of Pediatrics Sub-Committee on Accidental Poisoning and selected consultants have completed a list of essential equipment and appropriate drugs for care of emergencies encountered by the pediatrician in his office.

Drugs and equipment which should be available are contingent upon several factors — (1) Is the physician in solo practice? (2) Is he in a group practice? (3) How near is a hospital? (4) How well is the pediatrician versed in emergency medical care?

Equipment

1. Self-filling bag, valve, portable oxygen with mask, infant, child, adult sizes; (manual resuscitator bag, machine unit).
2. Oxygen cylinder with flow meter.
3. Endotracheal tubes, sizes 3-7, and adapter.
4. Esophageal airway.
5. DeLee suction (portable suction machine).
6. Laryngoscope with various blades: infant, child, adult.
7. Oral airways (double-ended tubes are useful); various sizes.
8. Cricothyrotomy needle, 14 gauge.
9. Levine tubes, 10-14; gastric lavage equipment.
10. I.V. tubing with microdrop appliance.
11. Cut-down tray, including polyethylene tubing, sterile, Teflon® needles.
12. Scalp vein infusion set.
13. Splints, all sizes.
14. Fluorescein eye strips.
15. Sutures.
16. Sterile 2x2", 4x4" gauze pads.
17. Sterile compresses.
18. Roller bandage, 1" x 5 yds., 2" x 5 yds.
19. Kling, various sizes.
20. Muslin roller bandage, 6x6".

21. Sheets for restraint, blanket.
22. Emergency tags.
23. Culture tubes.
24. Test tubes, sterile, with and without appropriate anti-coagulant.
25. Specimen bottles.
26. Dipstick.
27. Syringes, sizes 1, 2, 10, 20, 50, ml.
28. Insulin syringes, 100 units; regular insulin.
29. Needles, various lengths, 18/25 gauge.
30. Butterfly needles, #22.

Drugs

1. Activated powdered charcoal (Norit A) 500 mg. (If poisonous drug unknown, save vomitus or lavage material for laboratory analysis.)
2. Alcohol, 70 percent and/or other disinfectants.
3. Aminophylline, I.V. 250 mg/10 ml.
4. Antibiotics.
5. Aromatic spirits of ammonia.
6. Atropine sulphate, 0.4 mg/ml.
7. Diphenhydramine hydrochloride, 50 mg/ml.
8. Calcium chloride, 10 percent solution I.V. for cardiac resuscitation only; calcium gluconate, 10 percent solution, I.V., 10 ml ampules.
9. Dextrose, 50 percent solution, 50 ml.
10. Diazepam injection, 5 mg/ml.
11. Digoxin, 0.25 mg/ml.
12. Diphenylhydantoin hydrochloride, 100 mg. Steri-Vial with empty 2.5 ml syringe and ampule containing solvent.
13. DT, DTT, T toxoid, human immune globulin.
14. Epinephrine, 1-1000 (to be diluted appropriately for cardiac use).
15. I.V. fluids, 1/2 normal saline and 5 percent glucose; Ringer lactate solution.
16. Furacin® ointment and dressings.
17. Hydrocortisone sodium succinate; 100 mg ampules; dexamethasone sodium phosphate, 4 mg/ml.
18. Ice cubes.
19. Isoproterenol, 0.2 mg/ml. (1-5000 sol. I.V., I.M., Subcutaneous).
20. Lidocaine, 0.05 percent solution.
21. Morphine or meperidine hydrochloride.
22. Nalorphine hydrochloride, 0.2 mg/ml.
23. Sodium bicarbonate, ampules 50 ml (1 mg/1 ml.)
24. Sodium phenobarbital, ampules, 130 mg.
25. Sulfamylon® cream.
26. Syrup of ipecac.

It has been suggested that a child psychiatrist or general psychiatrist be available for immediate consultation, either in person or by telephone, if a psychiatric emergency arises in the pediatrician's office.

It is also recommended that the following phone numbers be conspicuously posted in all pediatrician's offices:

1. Local poison control center.
2. Local appropriate hospital.
3. Local police and fire departments; rescue squad.
4. Local health department.
5. Crisis intervention center.
6. Ambulance service.

Abstracted from "Emergency Medicine Today," AMA Commission on Emergency Medical Services, Volume 3, No. 10, John M. Howard, M.D., Editor. Original article can be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

Akers, Richard Edwin, MD (OPH), 631 Cox Rd., Gastonia 28052
 Askary, Nasser Agha, MD (OBG), 208 Leak St., Rockingham 28379
 Bomberg, Robert Bryan, MD (IM), 1910 Hillandale Rd., Durham 27705
 Castrovinci, Frederik, MD (PD), 3060-D Colony Rd., Durham 27705
 Creasman, William Thomas, MD (GYN), Box 3079, Duke Medical Center, Durham 27710
 Cuenca, Jose Maria, MD (RENEWAL) (OBG), P. O. Box 723, Boiling Springs, 28017
 Farnham, Robert, III, MD (Intern-Resident), 707 Caswell Road, Chapel Hill 27514
 Green, Arthur Gerrish, III, MD (Intern-Resident), 1139 Church St., Apt. A-1, Greensboro 27401
 Gupta, Jagmohan Dass, MD (Intern-Resident), 2843 Avent Ferry Road, Apt. 101, Raleigh 27606
 Haberkern, Roy Conrad, MD (PD), 904 Church St., Elizabeth City 27909
 Hartman, Randy Byron, MD (GP), Rt. 3, Box 146, Lawn-dale, N. C.
 Hawk, Robert Joe, MD (OBG), 202 S. Caldwell St., Brevard 28712
 Howald, Thomas Charles, MD (R), 27 Griffing Circle, Asheville 28804
 Kennedy, Thomas Francis, MD (R), Rt. 4, Box 2959, Asheville 28802
 Lapp, Charles Warren, MD (Intern-Resident), P. O. Box 518, Chapel Hill 27514
 Leone, Michael Ralph, MD (GS), 3408 Madison Ave., Greensboro 27403
 Lieu, Young-Ho, MD (GS), 503 E. Statesville Ave., Mooresville 28115
 Lowry, Roy Frank, Jr., MD (OPH), 240 Smith Church Rd., Roanoke Rapids 27870
 Martin, James Nello, Jr., MD (Intern-Resident), D-14 Wenner Gren Ctr., 11346 Stockholm 60, Sweden
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 Nieters, Gerald Francis, MD (R), 1011 S. Magnolia St., Mooresville 28115
 Payne, Winston Charles, MD (OPH), 4 Doctor's Park, Asheville 28802
 Sarn, James Edward, MD (Former Student Member), American Embassy, USAID, APO New York 09885
 Schwartz, Robert Paul, MD (PD), 710 Jefferson Dr., Charlotte 28211
 Sloan, James Boykin, MD (OPH), 1915 Glen Meade Rd., Wilmington 28401
 Slusher, M. Madison, MD (OPH), 631 Lichfield Rd., Winston-Salem 27104
 Smith, Robert Norwood, Jr., MD (OBG), 4335 Colwick Rd., Charlotte 28211
 Thompson, William Keith, MD (PD), 1411 Forest Park Dr., Statesville 28677
 Van Hook, Robert Meyer, MD (IM), 555 Jasin Drive, Gastonia 28052
 Wall, Jack Gardner, MD (R), 817 Chesterfield Ct., SW, Lenoir 28645

Wilkinson, Henry Alfred, MD (PTH), 2700 Beverwyck Rd., Charlotte 28211
 Williams, Paul Franklin, MD (OBG), 200 Memorial Dr., Jacksonville 28540

WHAT? WHEN? WHERE? In Continuing Education

January 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

Programs in North Carolina

January 22-24

North Carolina's Alcoholism Awareness Week—1975
 Place: Sheraton Crabtree Motor Inn, Raleigh
 Sponsors: N. C. Alcoholism Research Authority, N. C. Center for Alcohol Studies at UNC-Chapel Hill; N. C. Department of Human Resources, N. C. Jaycees; N. C. State Medical Society, N. C. Neuro-Psychiatric Association
 Program: Respective topics for the three days will be as follows: 22nd—Medical Health for the Alcoholic. At 7:30 p.m. Mrs. Marty Mann, founder of the National Council on Alcoholism, will speak in Christ's Episcopal Church, Raleigh, on "Alcoholism and You." 23rd—Alcoholism—The Search for the Sources. At the 7:00 p.m. banquet the main address will be given by Secretary David Flaherty, N. C. Department of Human Resources. 24th—First Annual North Carolina Alcoholism Researchers' Forum
 Fee: \$30 in-state; \$45 out-of-state. Pre-registration by January 7 is requested
 Credit: 13 hours AAFP continuing education credit applied for
 For Information: John A. Ewing, M.D., Executive Secretary, Alcoholism Research Authority, 623 E. Franklin Street, Chapel Hill 27514

January 24-25

Surgical Infections
 Fee: \$75
 Credit: 12 hours
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 31-February 1

North Carolina Medical Society 1975 Conference for Medical Leadership
 Place: State Society Headquarters Building, Raleigh
 Program: Designed especially for Society Officers and other members who carry leadership responsibility. Open to all interested Society members
 For Information: Mr. William N. Hilliard, Executive Direc-

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH **DYAZIDE**

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

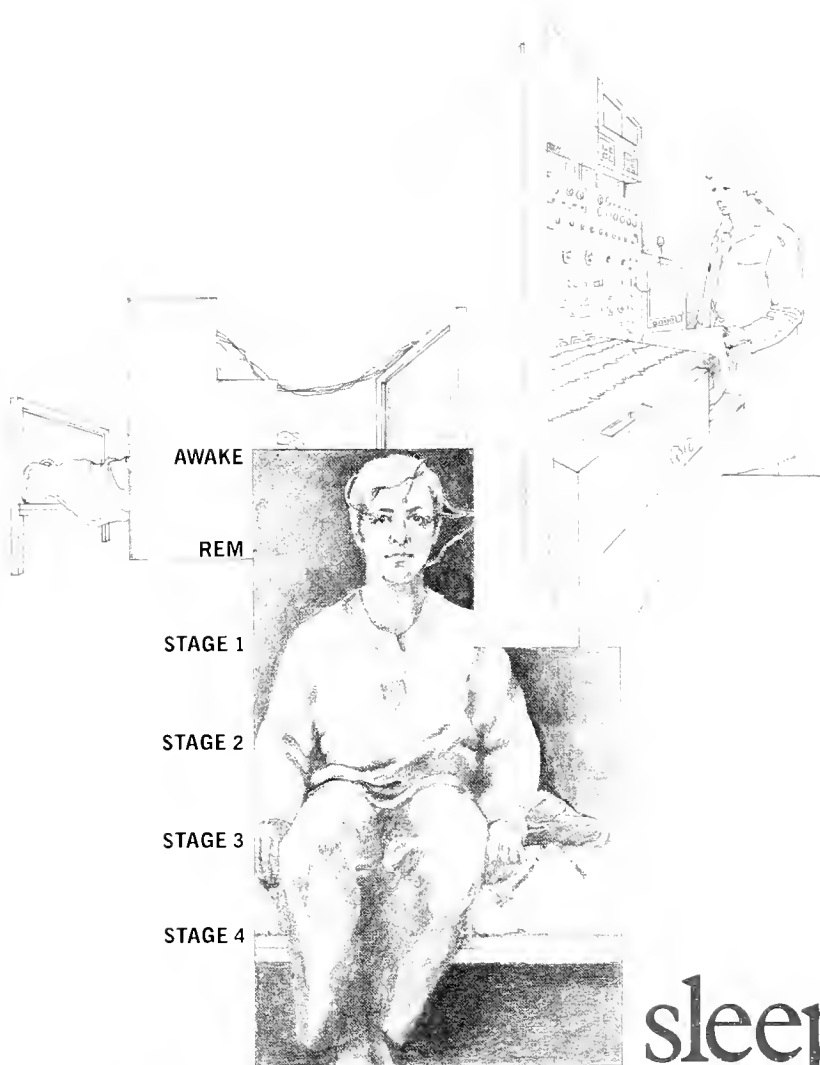
Just 'Dyazide' once daily or twice daily
No inconvenient potassium supplements
Nor special K⁺ rich diets needed as a rule



Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

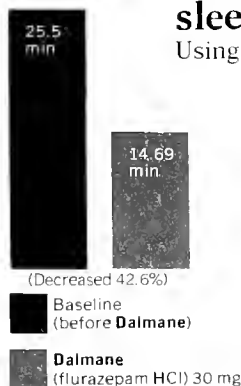


sleep
begins within
17 minutes, on average ...
an initial benefit of

Dalmane[®]
(flurazepam HCl) proved by a
22-night clinical study of insomnia patients
in the sleep research laboratory and at home¹

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.¹

Average Time Required
to Fall Asleep (4 Studies,
16 Subjects^{2,3})



confirmed by clinical studies in four geographically separated sleep research laboratories^{2,5}

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage²⁻⁵

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl



when restful sleep
is indicated

Dalmane[®] (flurazepam HCl)

One 30-mg capsule h.s. — usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule h.s. — initial dosage for
elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, et al: *Arch Gen Psychiatry* 23:226-232, Sep 1970

2. Karacan J, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971

3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

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Nutley, New Jersey 07110

When diarrhea has his number...



Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea

and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil[®]
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

Usually stops diarrhea promptly.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE

Searle & Co.
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

454 R

tor, North Carolina Medical Society, P. O. Box 27167,
Raleigh 27611

February 4-5

The Challenge of Aging—John W. Umstead Lecture Series
Special workshop sessions will be available on February 5th;
the banquet speaker at 8 p.m. on February 4th will be Dr.
Arthur S. Fleming, U. S. Commissioner on Aging, DHEW
Place: Royal Villa, Raleigh
Fee: \$5 for registration
Credit: AAFP credit applied for
For Information: William E. Thomas, Ph.D., Division of
Mental Health Services, 325 N. Salisbury Street, Raleigh
27611

February 7-8

Current Topics in Occupational Health
Place: Carolina Inn, Chapel Hill
Sponsors: Dept. of Community Health Sciences, Duke University Medical Center; Carolina Industrial Medicine Association; N. C. Association of Industrial Nurses
For Information: Leonard J. Goldwater, M.D., Dept. of
Community Health Sciences, Duke University Medical
Center, Box 2914, Durham 27710

February 14-15

Medical Ethics Symposium
Place: Babcock Auditorium
Fee: \$30
Credit: 15 hours
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of Medicine,
Winston-Salem 27103

February 17-18

Regional Diabetes Teaching Nurse Workshop
Fee: \$50
For Information: Judith E. Wray, Administrative Secretary,
Continuing Education Program, UNC School of Nursing,
Chapel Hill 27514

February 18-19

Medical Audit Team Seminars
Place: Royal Villa, Greensboro
Sponsors: N. C. Medical Records Association; N. C. Hospital Association; N. C. Medical Society
Fee: \$125
Credit: AAFP and AMA credit applied for
For Information: Mrs. Peggy Russell, RRA, Medical
Records Department, Lexington Memorial Hospital, Lexington 27292

February 19

Paraneoplastic Syndromes—the Wingate Johnson Memorial
Lecture
Place: Babcock Auditorium
Time: 11:00-12:00 a.m.
Speaker: Prof. A. McGehee Harvey, M.D., Johns Hopkins
Hospital, Baltimore, Maryland
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of
Medicine, Winston-Salem 27103

February 21-23

Regional Duke Medical Alumni Reunion
Place: Disney World, Orlando, Florida
For Information: Office of Continuing Medical Education,
Box 2991, Duke University Medical Center, Durham
27710

February 22

Learning Disabilities Seminar: A Course for Physicians and
Their Wives
Place: Babcock Auditorium
Sponsors: Auxiliary to the North Carolina Medical Society
and the Forsyth-Stokes Medical Auxiliary
Fee: \$5
Credit: 2 hours
For Information: Emery C. Miller, M.D., Associate Dean for
Continuing Education, Bowman Gray School of Medicine,
Winston-Salem 27103

February 28-March 2

Regional Duke Medical Alumni Reunion
Place: Las Vegas, Nevada
For Information: Office of Continuing Medical Education,

Box 2991, Duke University Medical Center, Durham 27710

First Medical District Postgraduate Course

There will be a presentation of two topics on each of six dates:

January 15—The Newer Immunology; Rheumatoid Arthritis

January 22—The Selection of Patients for Coronary Artery Bypass; The Results of Coronary Artery Bypass Surgery

January 29—Office Gynecology; Obstetrical Emergencies

February 5—Office Orthopaedics; Low Back Pain

February 12—Management of Common Skin Disorders;

Indication for Steroids in Dermatological Diseases

February 19—Evaluation of the Anemic Patient; Diffuse

Intravascular Coagulation (DIC)

Place: Edenton Restaurant, Edenton, except for January 22, when the meeting will be held at the Holiday Inn, Elizabeth City

Sponsors: 1st Medical District, North Carolina Medical Society with The Office of Continuing Education, UNC School of Medicine

Fee: \$75 for the six sessions, or \$15 per session

Credit: 12 hours; AAFP approved

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514, or, David O. Wright, M.D., Chowan Medical Center, Edenton 27932

March 3-4

Nutrition in Mothers, Infants, and Pre-School Children

Place: Carolina Inn, Chapel Hill

For Information: Dr. John J. B. Anderson, Department of Nutrition, School of Public Health, UNC, Chapel Hill 27514

March 12 & May 7

(two different workshops)

Toward More Effective Diabetic Teaching

Practical approaches to diabetic care, including some newer developments and less well-known aspects

Place: March 12—Reidsville; May 7—Raleigh

Fee: \$20

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 16-18

Neurosciences Seminar

Sponsors: Department of Psychiatry and the Veterans Administration Hospital, Duke University Medical Center

For Information: John L. Sullivan, M.D., Assistant Professor of Psychiatry, Veterans Administration Hospital, Durham 27705

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract

Place: Governors Inn, Research Triangle Park (between Durham and Raleigh, near the airport.)

Program: Designed for radiologists, but open to other physicians in training or practice. Emphasis on personalized, tutorial type teaching, with ample opportunity for discussion. Two 1 hour 20 minute tutorial sessions each morning, and one in the afternoon; 12 registrants will join one faculty member in a separate quiet room with viewboxes for organized film reading-discussions and case presentations. Each registrant will have a total of 14 different tutorial sessions. One hour "Panel" presentation-discussion each afternoon. Guest faculty include: Drs. Charles A. Bream, Harley C. Carlson, Joseph T. Ferrucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S. Wolf, and, from Kings College Hospital, London, England, Dr. John Laws, Chairman, Department of Radiology

Fee: \$300; enrollment limited

Credit: 28 hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 25-26

Problem-Oriented Medical Record System

Through a video-tape simulated case presentation, parti-

cipants will be involved in learning to use the POMR through actual involvement

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 27-28

The Nursing Audit

Designed to assist nursing administrative personnel in evaluating the quality of patient care through the use of a systematic auditing technique

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 28

9th Malignant Disease Symposium—Childhood Malignancy
Place: Berryhill Hall, UNC School of Medicine, Chapel Hill

Sponsors: Department of Pediatrics and the Office of Continuing Education

Fee: \$35

Credit: 5 hours; AAFP approved.

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 28-29

Eleventh Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning

The program is designed for practitioners and residents in Obstetrics and Gynecology. There will be three basic themes: "Fertility: Enhancement and Inhibition"; "Advances in Perinatology"; and "Human Sexuality: Problems that Confront the Gynecologist"

Fee: \$60; no charge for residents or students

For Information: Charles B. Hammond, M.D., P.O. Box 3143, Duke University Medical Center, Durham 27710

April 4-5

Pediatric Postgraduate Course

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 7-11

Practical Approaches to Diabetic Care

Program especially suitable for nurses caring for large numbers of diabetic patients. Emphasis on teaching needs of diabetic patients and how to meet them

Fee: \$125

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 10

Rheumatoid Arthritis—10th Annual Wilson Memorial Hospital Postgraduate Symposium

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

Speakers will include Dr. John Davis, University of Virginia Medical Center, Dr. Donald McCollum, Duke University Medical Center, Dr. Edwin Martinat, Bowman Gray School of Medicine and Dr. Carwile LeRoy, Columbia-Presbyterian Medical Center

For Information: A. Tyson Jennette, M.D., Wilson Memorial Hospital, 1705 South Tarboro Street, Wilson 27893

April 11

North Carolina Diabetes Association Eighth Annual Scientific Session

The program will include a scientific session for physicians and a separate and concurrent session for laymen

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 12-13

1st Annual Colloquium on Practical Rheumatology

Place: Carolina Inn, Chapel Hill

Sponsors: Division of Rheumatology and Clinical Immunol-

ogy, Department of Medicine with the Office of Continuing Education, UNC School of Medicine
Credit: AAFP credit applied for
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 21-22

Primary Nursing

Participants will explore the use of the primary system and its relationship to other systems, and identify its influence on the nursing process, patient care and staffing
Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 21-24

Recent Advances in Allergy

Place: The Homestead, Hot Springs, Virginia

Seminar sessions will be held from 8:00 to 10:00 on each of these four days

For Information: Claude A. Frazier, M.D., Building 4, Doctors Park, Asheville 28801

April 23-25

Maternal Health and Family Planning

Designed to assist nurses to conduct classes for parents in prepared childbirth

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 1-4

121st Annual Session of the North Carolina Medical Society: General Session on Scientific Subjects and Specialty Section Meetings

Place: Pinehurst Hotel and Country Club

For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh, N. C. 27611

May 12-13

Family Planning Seminar

Place: Carolina Inn, Chapel Hill

Sponsors: Department of Obstetrics and Gynecology: School of Nursing; Office of Continuing Education

Fee: \$50

Credit: 11 hours: AAFP approved

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 13-14

Breath of Spring, '75—Respiratory Care Symposium

Place: Babcock Auditorium

Sponsors: Division of Continuing Education, Bowman Gray School of Medicine; Northwestern Lung Association

Fee: \$25

Credit: 12 hours Category 1 AMA: AAFP applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem, N. C. 27103

May 28-29

Endoscopy Workshop

Place: Berryhill Hall, UNC School of Medicine, Chapel Hill

Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine

Fee: \$75

For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals

January 22—1 p.m. "TBA Nursing Conference"

January 29—1 p.m. "Pathology, Histology Tissue"

February 5—1 p.m. "TBA Nursing Conference"

February 12—1 p.m. "Post-Op Thoracotomy Care"

2 p.m. "Psycho-Physiological Process"

February 19—1 p.m. "Blood Gases"

2 p.m. "Neurological Diagnostics"

February 26—1 p.m. "Oral Cancer Detection & Treatment"

2 p.m. "Antibiotics: Uses and Abuses"

As this schedule has been subject to some change in the past, it might be advisable to check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)

Oteen—Stewart Scott, M.D., or Mary Ellen Lutz, R.N. (298-7911)

Salisbury—Mr. Dante Spagnolo (636-2351)

Programs in Contiguous States

January 8, 15, 22, 29

Medical Hypnosis

Place: Porter Auditorium (sixth floor), Sanger Hall

Time: 7-9 p.m.

Fee: \$50

For Information: Dr. Charles E. Smith, Department of Psychiatry, Medical College of Virginia, Box 907, MCV Station, Richmond, Virginia 23298

January 20-23

The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy

Sponsors: Department of Anatomy, in cooperation with the Division of Continuing Education, School of Medicine and School of Dentistry

Program: The primary teaching method of this course is the dissection of the head and neck. Fresh specimens (unpreserved), when available, are used to be as life-like as possible. Individual, surgical approaches and manipulations are welcomed. Lectures and demonstrations will augment the laboratory dissections

Tuition: \$180; \$95 for students in residency programs. Limited to 32 registrants

Credit: 40 hours: Academy of General Dentistry; AAFP

For Information: Dr. Hugo R. Seibel, Department of Anatomy, Medical College of Virginia, MCV Station, Richmond, Virginia 23298

January 25

Ventilatory Problems Workshop

Place: Holiday Inn, Oak Ridge, Tennessee

Fee: Tuition \$20; dinner dance \$18

Credit: 7 credit hours AMA Category 1; AAFP credit applied for

This workshop is intended for internists, surgeons, family practitioners and anesthesiologists who have an interest in the treatment of respiratory problems as well as critical care nurses and respiratory therapists

For Information: Doris Croley, Education Department, Oak Ridge Hospital, Oak Ridge, Tennessee 37830

February 9-15

Sixth Annual Family Practice Refresher Course

Place: Mills Hyatt House Hotel, Charleston, S. C.

Fee: Tuition is \$140; enrollment limited to 100; registration closes January 24. The fee includes the Social Hour and banquet Wednesday evening. Wives are cordially invited.

Credit: 38½ hours AAFP approved

For information: Vince Mosely, M.D., Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

February 16

Cancer of the Breast, a postgraduate course

Place: Hyatt Regency Atlanta Hotel, Atlanta, Georgia

For Information: A. Hamblin Letton, M.D., Secretary-Treasurer, The Southeastern Surgical Congress, 340 Boulevard N.E., Atlanta, Georgia 30312

February 17-20

Southeastern Surgical Congress, 43rd Annual Assembly, for Doctors & Nurses

Place: Hyatt Regency Atlanta Hotel, Atlanta, Georgia

For Information: A. Hamblin Letton, M.D., Secretary-Treasurer, The Southeastern Surgical Congress, 340 Boulevard N.E., Atlanta, Georgia 30312

February 24-28

Nuclear Medicine

Place: Conference Center, Williamsburg, Virginia

Sponsor: Department of Radiology, Medical College of Virginia

Fee: \$175; residents \$75; separate daily attendance \$50

Credit: 19¼ hours AMA; certificate of attendance awarded

For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

February 28-March 2

Annual Meeting Virginia Chapter American Academy of Pediatrics

Place: Colonial Williamsburg, Virginia

Fee: \$10

For Information: James H. Stallings, Jr., M.D., Secretary-Treasurer, Virginia Chapter American Academy of Pediatrics, 6503 N. 29th Street, Arlington, Virginia 22213

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

May 12-15

Cardiology for the Internist

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: American College of Cardiology; Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine, Atlanta, in cooperation with Georgia Heart Association

For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Rehabilitation of Stroke Patients

A series of workshops on rehabilitation of stroke patients will be conducted as a special project of the South Carolina Heart Association. The overall goal of the project, entitled "Regionalization of Specialized Nursing Home Services," is to upgrade the care of geriatric patients through the latest methodology in stroke patient care. Each workshop will consist of a two-day training session and a one-day follow-up session for review and evaluation. Dates and locations of the workshop sessions are as follows:

January	21-22	& March	6—Aiken, S. C.
January	28-29	& March	5—Orangeburg, S. C.
February	11-12	& April	8—Sumter, S. C.
February	18-19	& April	3—Columbia, S. C.
February	25-26	& April	9—Florence, S. C.
March	11-12	& May	1—Myrtle Beach, S. C.
March	18-19	& May	6—Spartanburg, S. C.

For Information: Mrs. Dolores J. Wilkie, P.O. Box 5937, Columbia, S. C. 29250

Sesquicentennial Seminars for Physicians

The programs will be presented by "world renowned medical teachers"

Credit: Continuing education credit for the AMA Physicians Recognition Award

Dates, department presenting the program, and speakers are as follows:

January	16-17	Physical Medicine—Dr. John V. Basmajian of Emory University
January	23-24	Laboratory Medicine—Dr. J. Roger Edson, University of Minnesota, Mayo Graduate of Medicine
February	10-11	Anesthesiology—Dr. Charles Ronald Stephen of Washington University, St. Louis
February	20-21	Biochemistry—Dr. Sidney Udenfriend of the Roche Institute of Molecular Biology
February	27-28	Biometry—Dr. Ching Chun Li, University of Pittsburgh

For Information: Department of Continuing Medical Educa-

tion, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P.O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

FAMILY HEALTH

The Family and Community Health Committees view their joint role in the 1974-1975 auxiliary program as an opportunity, through public education and volunteer services, to help auxiliaries identify individual and community health problems. Volunteers can help prevent and treat diseases and mental illness related to unemployment, poverty, poor housing, environmental hazards, accidents, poor nutrition, child abuse, alcoholism, excessive smoking and misuse of drugs.

Anticipating the effects of the "sudden evolution" (restructuring) of the family, the unit upon which our society is based, the American Medical Association and its auxiliaries suggest that many auxiliary programs and projects should be set up to protect and maintain the family unit.

Family Health and Community Health, two new committees, encompass health services which previously were assigned to health education and health services. The Family Health Committee will stress concerns in four general areas:

1. Self-discipline: nutrition and weight control; fitness and exercise; living productively for longevity; and use and misuse of drugs, alcohol and tobacco.

2. Family relationships: parenting; sexuality; broken and/or one-parent homes; pre-delinquent aid for youth; education regarding defective births; religion and family health; and human abuse.

3. Detection: testing and screening for sight and hearing loss, reading and other learning disabilities; diabetes; and hypertension.

4. Rehabilitation: home-oriented programs involving parents and retarded, crippled, seriously disturbed and foster children; counseling programs for families affected by sudden infant death syndrome; and tutoring programs.

Through the cooperative efforts of the Greensboro Family Life Council, Greensboro Association of Jewish Women and the Guilford County Medical Auxiliary, Dr. Ray Helfer was key speaker at a Child Abuse Forum held at the UNC-G campus, in November.

On February 22, 1975, the North Carolina Medical Auxiliary, Bowman Gray School of Medicine

and Forsyth-Stokes Medical Auxiliary will have a symposium on Learning Disabilities.

Family Health Service committees are planning other such programs to educate and inform communities throughout North Carolina.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

The National Multiple Sclerosis Society has awarded four researchers at the medical center grants totaling \$81,030.

Drs. Nelson L. Levy, assistant professor of immunology, Eugene D. Day, professor of immunology, Joe M. McCord, associate in biochemistry and medicine, and Allen D. Roses, assistant professor of neurology, have received grants of \$37,366, \$23,369, \$15,000 and \$5,295, respectively.

The awards range from six months to a year and a half, and will count toward Duke's \$162 million Epoch Campaign, a fund-raising effort begun in November 1973, which already totals more than \$50 million.

* * *

Four recently appointed assistant professors are Dr. Robert H. Harris, medicine; Dr. Patrick E. Logue, medical psychology; Dr. Thomas T. Long, medicine; and Dr. Donald Serafin, plastic and maxillofacial surgery.

Harris received his B.S. degree from Georgia Institute of Technology in 1962, and his M.D. degree from the Medical College of Georgia in 1966. He served his internship and residency at the University of Virginia Hospital, and came to Duke in 1972 as a research fellow in the Department of Medicine, Division of Nephrology.

Logue received his undergraduate training, M.S. degree in experimental psychology, and Ph.D. in counseling from the University of North Dakota. Prior to his recent appointment at Duke, Logue was assistant director of the Human Development Clinic at Florida State University in Tallahassee.

Long joined the Duke staff in 1972 as a research fellow in gastroenterology. He received his B.S. degree from Wake Forest University in 1962, and M.D. degree from the Bowman Gray School of Medicine in Winston-Salem.

Serafin received his undergraduate training and M.D. degree from Duke. He served a straight surgery internship at Grady Memorial Hospital in Georgia and general surgery residency at Grady and Emory University. He came to Duke in 1971 as an assistant resident in plastic surgery.

* * *

Receiving Distinguished Alumni Awards during medical alumni weekend at Duke were Dr. Stuart O. Bondurant, Jr., executive vice president and dean of

the Albany Medical College; Dr. Beverly C. Morgan, chairman of pediatrics at the University of Washington; Dr. Kenneth D. Weeks, a Rocky Mount physician; Dr. W. Delano Meriwether, a White House fellow serving as special assistant to the secretary of HEW; and Dr. Lewis W. Wannamaker, professor of pediatrics and microbiology at the University of Minnesota.

Medical alumni also made Duke President Terry Sanford an Honorary Alumnus and honored two Duke faculty members with Distinguished Teaching Awards. They were Dr. Talmage L. Peele, professor of anatomy, and Dr. Eugene A. Stead, who is Florence McAlister Professor of Medicine.

* * *

The main entrance building to the Duke Medical Center has been renamed the Barnes Woodhall Building. The dedication ceremony was part of medical alumni weekend.

Dr. Woodhall, who established and headed the neurological surgery service, went on to become dean of the School of Medicine, and associate provost, vice provost and chancellor pro tem of the university.

He currently holds the title of James B. Duke professor emeritus of neurosurgery.

* * *

Dr. David C. Sabiston, chairman of the Department of Surgery, has been elected chairman of the

A NEW LOOK AT KEOGH COULD BE WORTH \$7,500 IN INCOME DEDUCTIONS TO YOU THIS YEAR, IF YOU ARE SELF-EMPLOYED!!

The new PENSION REFORM ACT became effective on September 2nd. If you are self-employed, this new legislation offers you substantial new benefits in income tax deductions and in tax sheltered retirement fund growth. May we assist you in improving your present plan, or in creating a new one in time to qualify for maximum (\$7,500) tax deductions this year?

For more information, please return the attached coupon:

KEOGH-HR-10 SERVICES DIRECTOR
NML Associates
143 West Franklin Street
Chapel Hill, N. C. 27514

I would like information on how to achieve maximum benefits this year under a KEOGH SELF-EMPLOYED PLAN.

Name _____ Business _____

Address _____

City _____ State _____ Zip _____

Telephone _____

M.J.

Board of Governors of the American College of Surgeons. Earlier this year Sabiston was elected president of the Society of Surgical Chairmen.

* * *

Lynn Smiley, a medical school freshman, has been chosen by the Southern Medical Association to receive one of its \$500 scholarships. Ms. Smiley of Goodland, Kan., received a B.A. in microbiology at the University of Kansas in 1973.

* * *

The Duke chapter of the Alpha Omega Alpha (AOA) Honorary Medical Society honored its new members at the annual AOA induction banquet in November. Dr. Ewald W. Busse, director of medical and allied health education was the guest speaker.

Dr. Kenneth L. Pickrell, professor and chief of plastic and maxillofacial surgery, has been elected to faculty membership in the society. Dr. Robert H. Peter, associate professor of medicine, and Dr. Bailey Webb, associate clinical professor of pediatrics, were also chosen as new faculty members.

Elected as undergraduate members from the medical school junior class were Mary Ellen Gellerstedt, John Vick Mickey, James York Elgar Miller, Robert Benjamin Stein, Robert Marshall Tate and Katherine S. Upchurch.

New senior members are Andrew Anthony Bonin, Roger William Capello, Jr., Richard Marion Draffin, Maryann Forciea, Louis Frederick Fries III, William Elliott Johnston, Laurence Alan Lang, Michele Marlow, Arthur Robert Olshan, Worthington George Schenk III, David Warren Snyder and John Carson Hay Steele, Jr.

* * *

Duke Hospital's Room 3054, a surgical conference room, has been dedicated and renamed the Mary Johnson Hart Surgical Conference Room. Mrs. Hart is the wife of Dr. Deryl Hart, chairman emeritus of the Department of Surgery and president emeritus of Duke.

* * *

Awards totaling \$27,000 in research grants, clinical service grants and fellowships to Duke University scientists for the study of neuromuscular diseases have been approved, effective January 1, 1975, by the Muscular Dystrophy Associations of America (MDAA).

According to Alton Hinson, of Greensboro, Regional Coordinator for MDAA, recipients include: June-zoo Yeh, Ph.D., \$13,500 for a postdoctoral project in "Physiology involving the neuromuscular junction," and a postdoctoral fellowship of \$13,500 to Richard C. Carlsen, Ph.D., for work in "The development of central connectivity following limb transplantation and the role of the periphery in specifying the center." The work by these two scientists will be done at Duke University Medical Center in the Department of Physiology and Pharmacology.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Julian Keith, a Winston-Salem physician and a Forsyth County Commissioner, has been named chairman of the Bowman Gray School of Medicine's new Department of Family Medicine. The appointment was effective Dec. 1. Establishment of the department is part of the school's efforts to produce more primary care physicians. The department also will be involved in the school's participation in the statewide Area Health Education Center program.

Dr. Keith's initial responsibilities will be to recruit faculty for the new department, which will include four full-time family practitioners, a specialist in internal medicine, a general pediatrician and both an obstetrician-gynecologist and a psychiatrist who will work part-time in the program.

The department will have at least six residents during its first year, with that number to increase considerably over a three-year period.

* * *

An exhibit prepared at Bowman Gray won a first-place award at the 68th annual scientific meeting of the Southern Medical Association in Atlanta. The exhibit on "Familial Polyposis" was prepared by Dr. Howard G. Dawkins, resident in surgery, Dr. Thomas Vargish, resident in surgery, Dr. Thomas F. O'Brien, associate professor of medicine, and Dr. Richard T. Myers, professor and chairman of the Department of Surgery.

* * *

Bill Glance, director of information and publications, was installed recently as chairman of the Group on Public Relations of the Association of American Medical Colleges (AAMC).

The installation took place at the 85th annual meeting of the AAMC in Chicago. Glance succeeds Joe Sigler, director of public relations at Duke University Medical Center. Miss Helen Sims of the University of Kansas Medical Center was elected chairman-elect.

* * *

Dr. Thomas F. O'Brien, Jr., associate professor of medicine, has been installed as president of the Forsyth County Medical Society.

* * *

Norman Klase, Jr. has been appointed director of personnel for the medical school. He comes to Bowman Gray from Duke University, where he was manager of labor relations in the personnel department.

His work at Bowman Gray includes the recruitment of non-faculty personnel and selection of em-

employees, employee relations and benefits, employee training, and wage and salary administration.

* * *

Reid T. Holmes, who headed North Carolina Baptist Hospital for more than half of its 51-year history, retired Nov. 1 as president of the hospital.

The hospital is the principal teaching hospital for the medical school.

* * *

Dr. Robert A. Diseker, assistant professor of community medicine, was named program chairman for the Comprehensive Health Planning Section of the American Public Health Association at the fall meeting in New Orleans.

* * *

George Lynch, director of audio-visual resources, has been reappointed chairman of the Committee for Accreditation for Curricula in Medical Illustrations, and a member of the Council on Education of the Association of Medical Illustrators.

* * *

Dr. William S. Pearson, associate professor of psychiatry, has been appointed to serve on the membership committee of the North Carolina District of the American Psychiatric Association.

* * *

Dr. George Podgorny, clinical instructor in surgery, has been elected president of the North Carolina Chapter of the American College of Emergency Physicians, and appointed to the National Board of Directors of the American College of Emergency Physicians.

* * *

Dr. R. Winston Roberts, professor of ophthalmology, was elected vice-chairman of the Section on Ophthalmology for the Southern Medical Association, during the association's November meeting in Atlanta.

* * *

Dr. M. Madison Slusher, assistant professor of Ophthalmology, has been appointed to the Editorial Board of the *Southern Medical Journal*.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

David Lanier, fourth-year medical student at UNC-Chapel Hill, has miniaturized a technique, developed years earlier by UNC's Dr. Neil Kirkman, to monitor the diets of children with galactosemia, a rare genetic defect.

The work was done at the Biological Sciences Research Center of Child Development Institute at UNC-Chapel Hill. Dr. Kirkman heads the Center's Genetics Research Laboratory.

Because of the new simplicity of blood collection (only one drop of blood is required), children whose diets need closer monitoring can be visited as often as necessary by a public health nurse.

Dr. Kirkman said that once the precise technique is published in a scholarly journal, the new test can be performed in any large hospital.

* * *

Dr. Carl W. Gottschalk, Kenan Professor of Medicine and Physiology, and Dr. William E. Lassiter, professor of medicine, have been awarded a \$257,162 contract from the National Institute of Arthritis, Metabolism and Digestive Diseases to conduct a two-year evaluation of areas in nephrology and urology which require immediate and long-range research support.

The UNC physicians will head a 10-member coordinating committee from across the country. This committee will, in turn, oversee the efforts of 11 specialty committees, each of which is chaired by a nationally-recognized scientist.

* * *

Two professors at the UNC School of Medicine at Chapel Hill have received awards from the Research and Evaluation Department of the National Council on Alcoholism (NCA).

Fred W. Ellis, professor of pharmacology, and Harold J. Fallon, professor of medicine and pharmacology, were presented the NCA Volunteer Service Award for their work on the Peer Review Board.

* * *

In order to "humanize the practice of medicine," a Mexican medical school is beginning an innovative course of study for its students and has asked an anthropologist from UNC-Chapel Hill to participate.

Dr. Fritz Hafer will be on leave for 1975 to take part in the new plan at the medical school of the National Autonomous University of Mexico (UNAM) in Mexico City.

Hafer will direct a seminar on anthropology for medical school faculty members and will help the physicians shape the new curriculum, dubbed "Plan A-36."

Plan A-36 is designed to educate medical students to be general practitioners rather than specialists. The new plan will try to "carry teaching to real situations," Hafer said.

* * *

Measurement and sampling of industrial safety and health problems was the topic of a course held at UNC-Chapel Hill in November.

Sponsored by the Departments of Continuing Education and Environmental Science and Engineering at the UNC School of Public Health, the course describes various types of hazards in industrial hygiene measurement used in their evaluation. Approximately half the course was spent in the laboratory using measuring instruments.

The 17 participants from 14 states received in-

struction on noise and radiation measurements, heat stress and other related subjects.

* * *

Dr. Morris Schaefer, professor of health administration at UNC-Chapel Hill, has been reappointed a member of the World Health Organization's (WHO) Expert Advisory Panel on Public Health Administration.

This will be Schaefer's second five-year term as one of 50 international scholars and administrators who are drawn upon for committees on science and health practice, preparation of particular studies and papers, consultation and advice.

* * *

Problems between air quality maintenance and land use and transportation planning were explored Nov. 13-15 at UNC-Chapel Hill.

The three-day conference brought together key people in government, universities, research institutes and non-governmental groups to discuss current and emerging issues in these three areas. The impact of recent federal legislation also was reviewed.

The meeting was sponsored by the Triangle Universities Consortium on Air Pollution; U.S. Department of Transportation, Environmental Protection Agency, and Department of Housing and Urban Development.

AMERICAN COLLEGE OF PHYSICIANS

Among 296 physicians in the United States and Canada who have been made Fellows of the American College of Physicians, the following are practicing in North Carolina:

James R. Harper, M.D., Chapel Hill; Victor S. Behar, M.D., and John Laszlo, M.D., Durham; William H. Shapiro, M.D., Rutherfordton; Elisha T. Marshburn, Jr., M.D., Wilmington; A. Ray Newsome, M.D., and L. Earl Watts, M.D., Winston-Salem.

GOHORRHEA: RECOMMENDED TREATMENT SCHEDULES—1974*

Note: Physicians are cautioned to use no less than the recommended dosages of antibiotics.

UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

Drug regimen of choice

Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses, injected at different sites at one visit, and one gram of probenecid, by mouth, just before the injections.

Alternative regimens

A. Patients in whom oral therapy is preferred: Ampicillin, 3.5 gm, by mouth, and one gram pro-

* USDHEW, PHS, CDC, BSS, VDCD, Atlanta, Georgia.

Randomycin[®]

(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines. To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea:** In uncomplicated gonorrhea, when penicillin is contraindicated, Randomycin (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially followed by 300 mg q 12 h for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Randomycin (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Randomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev 6/73



WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512



When the focus is on bronchitis due to susceptible strains of *H. influenzae* and pneumococci*

Randomycin[®] 300 mg.
[methacycline HCl] Capsules

Delivers from the very first dose:

Studies show that after the first dose serum levels rapidly rise above minimum *in vitro* inhibitory concentrations

*Since many strains are known to be resistant, routine sensitivity testing is recommended.

The Role of the Detail Man

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Willard Gobbell
Family Physician
Encino, California

Dr. Jeremiah Stamler
Chairman
Department of Community
Health and Preventive
Medicine, and Dingman
Professor of Cardiology
Northwestern University
Medical School



"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be — and at times actually are — disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets — some of it scientifically sound and therefore truly useful — as well as some excellent film produced by the pharmaceutical industry. When they function in thi

Opinion
&
Dialogue

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love — they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



benecid, by mouth, administered at the same time. This regimen may be slightly less effective than the recommended APPG regimen.

B. Patients who are allergic to the penicillins (penicillin G, ampicillin) or probenecid*:

1. Tetracycline hydrochloride, 1.5 gm initially, by mouth, followed by 0.5 gm, by mouth, four times each day for four days (total dosage, 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single-dose therapy.

2. Spectinomycin hydrochloride, 2.0 gm intramuscularly, in one injection.

Treatment of sexual partners

Men and women with known recent exposure to gonorrhea should receive the same treatment as individuals known to have gonorrhea. Male sex partners of persons with gonococcal infection must be examined and treated because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men.

Followup

Followup urethral and other appropriate cultures should be obtained from men, and cervical, anal and other appropriate cultures should be obtained from women, seven to 14 days after completion of treatment.

Treatment failures

Most recurrent infection after treatment with the recommended schedules is due to reinfection. Treatment failure after therapy with penicillin, ampicillin or tetracycline should be treated with 2.0 gm of spectinomycin intramuscularly.

Postgonococcal urethritis

Tetracycline, 0.5 gm, four times daily, by mouth, for at least seven days.

Pharyngeal infection

Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Pharyngeal gonococcal infection requires post-treatment cultures. Ampicillin and spectinomycin recommended for anogenital gonorrhea are ineffective in pharyngeal gonorrhea. Patients with pharyngeal gonorrhea, whose infection is not eradicated after treatment with 4.8 million units of APPG and one gram of probenecid, may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (Alternative Regimens).

Syphilis

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis who are receiving the recommended parenteral penicillin schedule need not have followup serologic tests

for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a followup serologic test for syphilis after three months to detect untreated syphilis.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Not recommended

Long-acting forms of penicillin (such as benzathine penicillin G) and oral penicillin preparations such as penicillin V.

TREATMENT OF UNCOMPLICATED GONORRHEA IN PREGNANT PATIENTS

A. For women who are not allergic to penicillin: Use the regimens of aqueous procaine penicillin G plus probenecid, or ampicillin and probenecid, as defined above.

B. Pregnant patients who are allergic to penicillins (of the alternative regimens, each has potential disadvantages):

1. Erythromycin, 1.5 gm orally, followed by 0.5 gm four times a day for four days, for a total of 9.5 gm. This regimen is safe for mother and fetus, but efficacy has not been established. Erythromycin estolate should not be used in patients with underlying liver disease.

2. Cefazolin, 2 gm intramuscularly, with 1.0 gm of probenecid. Because of the possibility of cross-allergenicity between penicillins and cephalosporins, this regimen should not be used in a patient with a history of penicillin anaphylaxis.

3. Spectinomycin, 2 gm intramuscularly. This is an effective dose, but safety for the fetus has not been established.

Contraindicated

Tetracycline should not be used for uncomplicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

The diagnosis of acute salpingitis should be considered in women with acute lower abdominal pain and adnexal tenderness on pelvic examination. Since there are no completely reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis, endocervical cultures for *N. gonorrhoeae* are essential. Therapy, however, should be initiated immediately.

A. Hospitalization should be strongly considered for women with suspected salpingitis in these situations:

1. Uncertain diagnosis, where surgical emergencies must be excluded.
2. Suspicion of pelvic abscess.
3. Pregnant patients with salpingitis.
4. Inability of the patient to follow an outpatient

* Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction.

regimen of oral medication, especially because of nausea and vomiting.

5. Failure to respond to outpatient therapy.

B. *Antimicrobial agents*: Controlled studies of the treatment of acute salpingitis are not available. Initial management must *AT LEAST* be adequate for gonococcal salpingitis. These regimens are adequate for the treatment of gonococcal salpingitis:

1. Outpatients:

(a) 1.5 gm tetracycline hydrochloride, a single oral loading dose, followed by 500 mg, four times daily for ten days.

(b) Aqueous procaine penicillin G (AAPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, or 3.5 gm of oral ampicillin. One gram of oral probenecid with either penicillin or ampicillin, both followed by 500 mg of ampicillin, orally, four times daily for ten days.

2. Hospitalized patients:

(a) Aqueous crystalline penicillin G, 20 million units, given intravenously each day until improvement, followed by 500 mg of ampicillin, orally, four times daily, for ten days. The need for additional or alternative antibiotics for the treatment of nongonococcal salpingitis requires further study. Since it is impossible to distinguish gonococcal from nongonococcal salpingitis clinically, many physicians also use an aminoglycoside in addition to penicillin and/or antibiotics which are effective against *Bacteroides fragilis* as initial therapy.

(b) Tetracycline hydrochloride, 500 mg, given intravenously four times daily until improvement, followed by 500 mg, orally, four times daily, for ten days. This regimen should not be used for pregnant women or patients with renal failure.

3. Failure to improve on the recommended regimen does not necessarily indicate the need for step-wise additional antibiotics, but requires reassessment of the possibility of other diagnoses and of the specific microbial etiology.

C. The effect of the removal of an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis requires further study.

D. *Adequate treatment of women with acute gonococcal salpingitis must include examination and appropriate treatment of their male sex partners because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men. Failure to treat male sex partners is a major cause of recurrent gonococcal salpingitis.*

E. Followup of patients with acute salpingitis is essential. All patients should receive repeat pelvic examinations and cultures for *N. gonorrhoeae* after treatment.

DISSEMINATED GONOCOCCAL INFECTION

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

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caffeine gr ½

*Warning—may be habit-forming



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1. Aqueous crystalline penicillin G, 10 million units intravenously per day for three days, or until there is significant clinical improvement. This may be followed with ampicillin, 500 mg four times a day orally, for seven days.

2. Ampicillin, 3.5 gm orally, and probenecid, 1.0 gm, followed by ampicillin, 500 mg four times per day orally, for at least seven days.

B. In penicillin and/or probenecid allergic patients:

1. Tetracycline, 1.5 gm orally, followed by 500 mg four times a day orally, for at least seven days. Tetracycline should not be used for complicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

2. Erythromycin, 0.5 gm intravenously every six hours, for at least three days.

C. Additional measures:

1. Hospitalization is indicated in patients who are unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

2. Immobilization of the affected joint(s) appears helpful. Repeated aspirations and saline irrigations appear beneficial, but controlled studies of these procedures have not been performed. Open drainage of joints other than the hip is now generally discouraged in patients with gonococcal arthritis.

3. Intra-articular administration of penicillin is unnecessary, since penicillin levels in the synovial fluid of inflamed joints approximate serum levels; furthermore, intra-articular injection per se may produce a toxic synovitis.

D. Meningitis and endocarditis due to the gonococcus require high-dose intravenous penicillin therapy (at least 10 million units per day) for longer periods: usually at least ten days for meningitis and three to four weeks for endocarditis.

GONOCOCCAL INFECTION IN PEDIATRIC PATIENTS

Pediatric patients (from birth to adolescence) who are post-pubertal and or weigh more than 100 pounds, should be treated with dosage regimens as defined above for adults.

WITH GONOCOCCAL INFECTION IN CHILDREN, THE POSSIBILITY OF CHILD ABUSE MUST BE CONSIDERED!

The efficacy of therapeutic regimens for uncomplicated and complicated gonococcal infections of childhood is unproven.

Prevention of neonatal infection

All pregnant women should have endocervical cultures examined for gonococci as an integral part of prenatal care.

Prevention of gonococcal ophthalmia

A. One percent silver nitrate (do not irrigate with saline, as this may reduce efficacy).

B. Ophthalmic ointments containing tetracycline,

erythromycin or neomycin are also probably effective.

C. NOT RECOMMENDED: Bacitracin ointment (not effective) and penicillin drops (sensitizing).

Management of infants born to mothers with gonococcal infection

Orogastric and rectal cultures should be taken from all patients. Blood cultures should be taken if septicemia is suspected. Aqueous crystalline penicillin G, 50,000 units/kg/day, should be administered in two daily doses intravenously, if cultures or Gram-stained smears reveal gonococci. Duration of therapy should be determined by clinical response. In suspected septicemia, an aminoglycoside should also be administered.

Neonatal disease

A. Gonococcal ophthalmia: Patient should be hospitalized. Antimicrobial agents: Aqueous crystalline penicillin G, 50,000 units/kg/day, in two or three doses intravenously for seven days, and frequent saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops.

B. Complicated infection: Arthritis and septicemia should be treated by hospitalization and administration of aqueous crystalline penicillin G, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day, in two doses, for seven days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into two or three daily intravenous doses and continued for at least ten days.

Childhood disease

Gonococcal ophthalmia should be treated with hospitalization and by the administration of aqueous crystalline penicillin G intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, intramuscularly, 75,000-100,000 units/kg/day, in two doses, for seven days, and saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops. Topical antibiotics *alone* are *NOT* recommended in therapy of gonococcal ophthalmitis. The source of the infection must be identified.

Uncomplicated vulvovaginitis and urethritis usually do not require hospitalization. Both may be treated at one visit with aqueous procaine penicillin G, 75,000-100,000 units/kg intramuscularly, and probenecid, 25 mg/kg by mouth. Topical and systemic estrogen therapy are of no benefit in vulvovaginitis. All patients should have followup cultures, and the source of infection should be identified, examined and treated.

Infection complicated by peritonitis or arthritis should be treated by hospitalization and administration of aqueous crystalline penicillin G, intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day intramuscularly, in two doses for seven days.

Treatment of patients with allergy to penicillin: Patients under six years of age should be treated with erythromycin, 40 mg/kg/day, in four doses by mouth, for seven days, for uncomplicated disease. Complicated disease should be treated with cephalothin, 60-80 mg/kg/day in four doses intravenously, for seven days. Patients older than six years may be treated with an oral regimen of tetracycline, 25 mg/kg, as an initial dose, followed by 40-60 mg/kg/day in four doses, for seven days, or an intravenous regimen consisting of tetracycline, 15-20 mg/kg/day, in four doses, for seven days.

NEWSNOTE

Mac Roy Gasque, M.D., has been appointed to a newly created position of vice president and director, Health Affairs of the Olin Corporation. In making this announcement, Olin's president, John M.

Henske, said, "Doctor Gasque's appointment was made in recognition of his exceptional contributions to Olin in the fields of industrial and preventive medicine." He has made his offices at the company headquarters in Stamford since 1968.

Dr. Gasque has been a leading advocate of employee and environmental health programs, particularly of early detection and treatment of disease, for more than a quarter-century.

He received his M.D. degree from the University of Virginia Medical School, has been a visiting lecturer in preventive medicine for many years at the Duke University Medical School and is now associate clinical professor of environmental medicine at the New York University Medical School.

Dr. Gasque is a native of North Carolina, having been born in Olin. He was a Founder and first president of the Carolina Industrial Medical Association and has been a member of the North Carolina Medical Society since 1947.

Month in Washington

The only two crucial health bills that have an outside chance of passage in the 93rd Congress face tough sledding in the remaining "lame-duck" days, mostly due to the wide differences between the House and Senate versions.

The House Commerce Committee has approved and sent to the floor for action an Aid-For-Medical Education bill requiring medical school graduates to pay back the federal government for its contribution to their education through capitation assistance, or serve in shortage areas.

Another provision of the House Committee bill establishes an agency for accrediting medical residency training programs and for limiting the number of positions in each program. The total would equal 125 percent of the estimated number of graduates from U.S. medical schools, thus imposing a ceiling on the number of slots that could be filled by Foreign Medical Graduates. Some 7,000 residencies could be eliminated if this limitation were imposed now.

The Senate has approved a manpower bill much broader in overall scope than that of the House, but the Administration, the American Medical Association, and the Association of American Medical Colleges vigorously oppose both bills. As a result of this controversy and the shortage of time remaining, both health manpower bills may founder this year.

A one-year extension of present aid programs is

the alternative. The AMA and others support this latter course.

Health planning bills are also pending in the Senate and House. Both bills have been substantially modified from the original versions which called for a tough regulatory structure for the health sector similar to sanctions which now govern the operations of public utilities.

The arguments of the AMA and other groups have prevailed, and a rate setting provision has been struck from the House bill. However, the Senate bill still contains authority for government regulation of hospital rates.

The AMA opposes the Senate bill because:

(1) The bill represents a mechanism for the regulation of the health care delivery system.

(2) Control of the planning and regulation process would not be at the local level, but would be directed from HEW.

(3) Health care would be subject to public utility type regulation. "There is no proven basis for adopting this extreme system of controls," the AMA asserts.

(4) State legislatures would be required to adopt certificate of need legislation to implement state programs of control meeting the satisfaction of the HEW Secretary.

(5) States would be expected to establish rates for

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all health services, which, through regulation, could cover all institutional and ambulatory services, including professional charges. HEW is empowered to establish criteria respecting basic elements of the rate structures.

(6) Control of the health sector would be federalized through the broad authority vesting such power in HEW.

(7) The complicated planning program proposed in the bill "could delay health resource development and adversely affect health services," according to the AMA.

Similar, but less strenuous, objections were raised by AMA against the more moderate planning bill approved by the House Commerce Committee. "While the bill does not contain the original public utility type controls proposed, which included rate setting authority in the states, the bill does establish a controlled planning system embracing characteristics of a public utility type approach to the regulation of health services and facilities," according to the AMA.

"The bill should be rejected and the existing authorities for Comprehensive Health Planning and Regional Medical Programs should be extended until an appropriate alternative is developed," the AMA argues.

The great difference between the House and Senate versions of both the planning and manpower bills, the opposition of almost all provider groups, and the time bind would seem to reduce greatly the passage of either bill this year.

* * *

President Ford has indicated that the national health insurance plan he will submit to the next Congress will be similar to former President Nixon's Comprehensive Health Insurance Plan (CHIP) which was based on mandatory coverage of workers by employers through the existing private health insurance system. In a legislative message to "lame-duck" Congress, Ford made no pitch for action in the present Congress.

Meanwhile, HEW Secretary Caspar Weinberger has been meeting with principal medical and health care providers, including the AMA, in an effort to arrive at some sort of consensus with respect to an NHI bill.

The AMA has provided the Secretary and other providers with a 14-point set of principles that it believes essential in any NHI plan. Approved by the AMA Board of Trustees, these NHI guidelines are:

(1) Minimum federal involvement in administration of any national health insurance program.

(2) State jurisdiction with respect to licensure and certification of professional health personnel and regulation of insurance.

(3) Minimum federal dollars in financing of programs for comprehensive coverage at least possible cost.

(4) Funding through federal, state and private

funds including (a) employer-employee contributions for private health insurance and (b) an individual tax credit as applied for full health care protection.

(5) No added Social Security tax for financing.

(6) No administration by Social Security.

(7) Cost sharing by participating individuals and families and a subsidy for the indigent, scaled according to income.

(8) Use of private insurance on risk and underwriting basis.

(9) Comprehensive coverage, basic and catastrophic, for the entire population.

(10) Pluralism in methods of health care delivery.

(11) Cost controls as appropriate.

(12) Quality controls as appropriate.

(13) Continuity of benefits.

(14) Coordination of benefits.

* * *

The Government has issued its long-promised regulations to encourage purchase of lower priced drugs for the Medicare and Medicaid programs, and introduced a new wrinkle — a drug price information bulletin to be sent to all physicians.

Major impact of the regulations, if finally carried out, would be on physicians and pharmacies dealing with Medicaid patients and their outpatient drug benefits. The inpatient Medicare program involving

hospital drug purchase would be less affected. However, the long-range implications of the HEW Department's plan in the event of a National Health Insurance Plan are significant. HEW would clearly attempt to extend something like the Medicaid proposal for outpatient drugs to any national program that reimbursed such costs.

The new regulations are aimed at reimbursement for the lowest price drugs available where the drugs are chemically identical. The limit is termed "maximum allowable cost," or MAC. Physicians prescribing for Medicaid patients would have to prescribe the designated drug or certify the necessity for prescribing a more expensive drug, and give reasons.

HEW gave interested parties 60 days to comment on the proposals. After that, and assuming the final regulations are little changed, the only possibilities for blocking the drug pricing plan would be court action or legislation. A Food and Drug Administration spokesman told a news conference the HEW Department has "ample legislative authority" to promulgate such regulations. He estimated the plan would save federal and state governments at least \$89 million a year when fully implemented in several years.

Pharmacists would be limited to their actual acquisition cost and a dispensing fee. According to HEW, pharmacists in many state Medicaid programs

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

TEGA-VERT SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol).....	50mg
NIACIN.....	50mg
DIMENHYDRINATE (Dramamine).....	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome, Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

REMARKS: Federal law prohibits dispensing without a prescription.

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are presently reimbursed on the basis of a published wholesale price "which may be more than 15 percent higher than the actual cost of acquisition."

Under the proposal, HEW would concentrate on the 200 most widely-used drugs; some 12 to 20, if all goes according to plan, would be placed on the MAC list this summer.

The reimbursement plan would have the greatest impact on drugs that aren't presently under patent protection and therefore come from several sources; approximately 40 of the top 200 fall in this category.

A Pharmaceutical Reimbursement Board would be set up at HEW to determine the maximum allowable costs. FDA would have to establish bio-equivalence to its satisfaction. An advisory committee would have a shot at the data and the recommendations before they were proposed formally.

The Pharmaceutical Manufacturers Association (PMA) said that, though it recognizes the need to hold down federal spending, it believes many questions and problems are involved in the proposals. One is the professional role of the pharmacist and the physician in the prescribing process, according to the PMA. Another worry is the possible discouragement of innovation and improvement of drugs, PMA said.

* * *

Tax provisions that would have affected physicians and patients were dropped from the "mini-tax" reform measure recently approved by the House Ways

and Means Committee, ending chances of these provisions' reaching enactment any time soon.

The provisions chopped from the bill included a proposal to eliminate the present deduction for one-half the premium cost for private health insurance up to \$150; a plan to deny business treatment for conventions or meetings arbitrarily held in exotic foreign locales; and a recommendation to place a deductible in front of legitimate business expenses for such items as professional dues and books.

* * *

The federal government is now providing 33 cents of every health care dollar spent in this country, according to a unique report made annually by the AMA-Washington office.

Actual dollar outlays in any given year may vary considerably from the appropriations provided by Congress, but the appropriations figure used by the AMA gives as accurate guideline as any other yardstick available on the nation's year-to-year health spending.

During the fiscal year that ended last July, the federal government disbursed more than \$32.7 billion for health, up \$2.6 billion from the previous year, and more than \$12 billion for disability programs. Total spending from all sources on health was estimated at approximately \$100 billion.

The federal tab for the current fiscal year, ending in July 1975, is slated to register a sharp jump as

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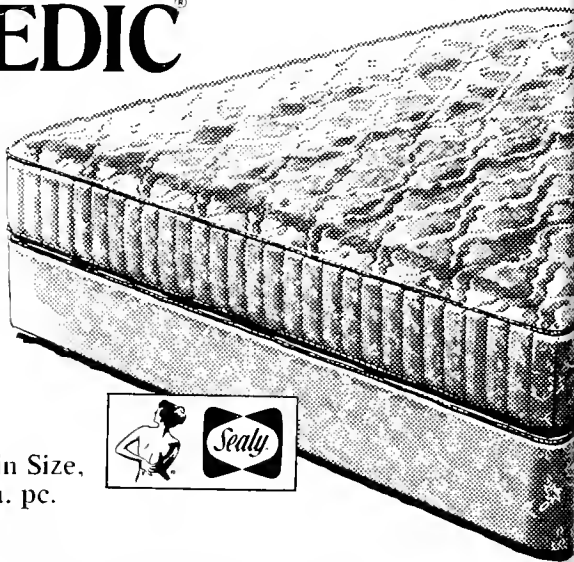
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new federal programs get going and increased overall health care costs are reflected.

The HEW Department leads the list of government health spenders with \$23.7 billion appropriated last fiscal year for its many health activities including Medicare and Medicaid. Next in line were Defense, \$3,065,274,500, and Veterans Administration, \$3,016,853,000. Fourth and fifth slots are occupied by relatively recent federal activities—the Federal Employees Health Insurance program—\$696.6 million — and the Environmental Protection Agency, \$528.9 million. Agriculture comes next at \$302.7 million for animal disease control, research, meat inspection, etc. (not counted are \$7.8 billion for health related programs of food for school children, and rural housing, water and waste disposal activities).

Medicare is the single largest federal health plan

moneywise. Though financed out of Social Security taxes, it technically remains an appropriation that must be approved by Congress each year. Cost of Medicare last fiscal year was \$12.1 billion, a \$2.5 billion increase due to increased utilization, higher costs, and the new program for the disabled, including kidney disease patients, which accounted for \$1.25 billion.

Of the Medicare total, almost \$3 billion was paid out for the supplemental insurance plan for outpatient benefits. Half the premium is paid for by the beneficiaries.

The federal government allotted \$5.8 billion to the states for the Medicaid program for medically indigent people, an increase of almost \$1 billion due to expansion of categories eligible for such assistance. If federal, state and local funds are counted, Medicaid costs \$10.5 billion.

Book Reviews

The Uncertain Miracle. Vance H. Trimble. 236 pages. Price, \$6.95. New York, N. Y.: Doubleday & Company, Inc., 1974.

Vance Trimble is currently the editor of the *Kentucky Post* and *Times Star* in Covington, Kentucky. He has a national reputation as an investigative reporter, winner of the Raymond Clapper Award for distinguished Washington correspondence and the Pulitzer Prize. He has applied his investigative and reportorial gifts in a very readable account of the history and current clinical applications of hyperbaric oxygenation.

He traces the history of hyperbaric medicine through early diving bells, and subsequently caissons, which enabled man to excavate in harbors and tunnels, but which sometimes resulted in "caisson disease" or the "bends" requiring slow decompression to allow trapped nitrogen to escape from tissues.

In the early 1800s hyperbaric therapy became a rage in Europe and was used extensively over a 40-year period for a wide variety of pathological states; but it lost its glamour and faded from clinical use.

Interest was revived in this country during the influenza pandemic of 1918 for the treatment of pneumonia. Successes with this therapy stimulated the construction of larger tanks, culminating in the construction in Cleveland, Ohio, of a completely hyperbaric hospital, five stories tall with bedrooms,

dining rooms and recreation areas. At this point, Dr. Orval J. Cunningham, internist and anesthesiologist, who was the guiding medical spirit behind this revived movement, became engaged in a long, bitter debate with the AMA's Bureau of Investigation, principally Morris Fishbein. The Bureau challenged the validity of the hyperbaric treatments and demanded solid scientific proofs of efficacy and safety. Dr. Cunningham never satisfied their demands, and the AMA denouncement, coupled with the 1929 stock market crash, tolled the death knell for this enterprise.

Trimble then follows hyperbaric treatment through the early blue-baby surgery at Harvard, and through subsequent treatment of carbon monoxide poisonings, trauma victims and respiratory disease syndrome (RDS) cases, including that of Patrick Kennedy.

Since those days, International Congresses on hyperbaric medicine have been held annually, and many new chambers have been constructed throughout the world.

Mr. Trimble then turns to current proven hyperbaric use and to some of the more interesting "less proven" clinical applications.

He has done an excellent job of research on this subject. He writes in a very readable style. There are several small technical errors pertain-

ing to the content of oxygen in the blood under hyperbaric conditions. I feel that he tends to minimize the dangers of oxygen toxicity—a very real danger under hyperbaric conditions. There are definite clinical conditions under which hyperbaric oxygenation can save the lives of patients when other measures are ineffective—extensive gas gangrene infections, carbon monoxide intoxication, “bends,” and as a surgical adjunct in occasional “blue-baby” operations. Use of hyperbaric techniques in other clinical states is currently unproved, but an open mind should be employed as further scientific clinical research proceeds.

ROBERT L. GIBSON, M.D.

Human Anatomy Review. Royce L. Montgomery, Ph.D., and Mary C. Singleton, Ph.D. 304 pages. Price, \$8.00. New York, N. Y.: Arco Publishing Company, 1974.

This volume is a comprehensive regional review of gross anatomy, presented in the form of the objective examination. An initial list of ten publications

for reference includes major systemically arranged books, regional discussions, clinical and surgical publications, and one of the human developmental volumes. Each region covers approximately 100 to 500 questions of multiple choice, selection or identification types. Each question is followed by references to one of the suggested publications by its numerical order and a page number. The section including questions for a region is followed by a numerically correlated answer section, supplemented by short explanatory sentences.

The authors are to be congratulated on a thorough coverage of anatomical material, well worded questions with minimal ambiguity, and a readily followed format. As they have emphasized, the book under no circumstances should be used for initial study. It should prove to be a valuable self-testing instrument for the student prior to periodic or final examinations during a course in gross anatomy, and it is ideally suited to study for state or national boards which characteristically employ the objective method of examination.

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In Memoriam

WILLIAM McNEAL NICHOLSON, M.D.

Dr. William McNeal Nicholson, a member of the Duke University School of Medicine faculty for nearly 40 years, died September 8, 1974. He had been in declining health for several months.

Dr. Nicholson was born in Bath, North Carolina, September 27, 1905.

He did his undergraduate work at Duke, earning an A.B. degree in 1927, and an M.D. degree from Johns Hopkins University Medical School in 1931. He served his residency and post-graduate work at Johns Hopkins Hospital from 1931 to 1935.

Dr. Nicholson came to Duke University Medical School in 1935 as an instructor in medicine. In 1936 he was made an associate in medicine, assistant professor in 1942, associate professor in 1946, and full professor in 1952. He was appointed chief of the metabolism clinic in 1940, holding this post until 1955. He was made assistant dean in charge of continuing medical education from 1949 to 1968—emeritus 1969 to 1974. He was director of the Duke University Medical post-graduate course given yearly at Morehead City.

Although he was keenly interested in all phases of internal medicine, Dr. Nicholson's special interest was in the field of metabolic diseases. He was a recognized authority in the treatment of diabetes and was the author or co-author of many published scientific articles.

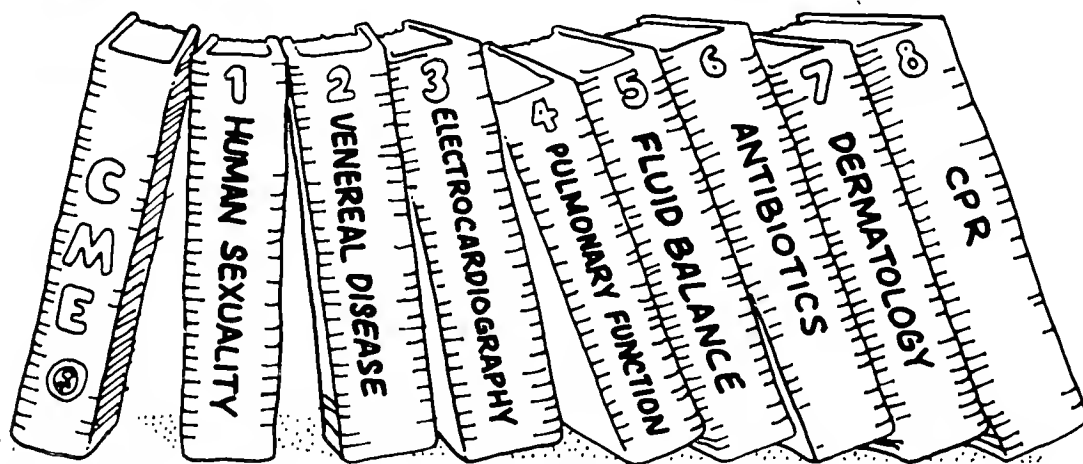
He was a member of numerous professional organizations and medical honoraries: president of the Durham-Orange County Medical Society from 1952 to 1953, chairman of the editorial board of the NORTH CAROLINA MEDICAL JOURNAL, secretary of the medical section of the Southern Medical Association from 1946 to 1947, and later was chairman of the medical section in 1948. He was a member of the American Medical Association, American Board of Internal Medicine, American College of Physicians, American Diabetes Association, American Society for Clinical Investigation, American Chemical-Climatological Society, Alpha Omega Alpha, Phi Beta Kappa and Sigma Xi. He was also a member of the North Carolina Air Control Council.

Bill Nicholson was a warm, gracious man. He was loved and held in deep affection by his students, colleagues and patients.

Dr. Nicholson is survived by his wife, Eunice Stamey Nicholson; a daughter, Mrs. Anne Nicholson Grose of Loraine, Ohio; two sons, William McNeal Nicholson, Jr., of Greensboro and Navy Lt. Samuel Thorne Nicholson of Charleston, South Carolina; two sisters, Blance Nicholson Webb of Greensboro and Mary Nicholson Wolfe of Forty Fort, Pa.; and nine grandchildren.

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Precautions:

ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual



precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduc-

tion; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral: Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

For Parenteral Administration: Should be individualized according to diagnosis and response. While 300 mg may be given during a 6-hour period, do not exceed this dose in any 24-hour period. To control acute conditions rapidly, the usual initial adult dose is 50 to 100 mg I.M. or I.V. Subsequent treatment, if necessary, may be given orally. (See Precautions.)

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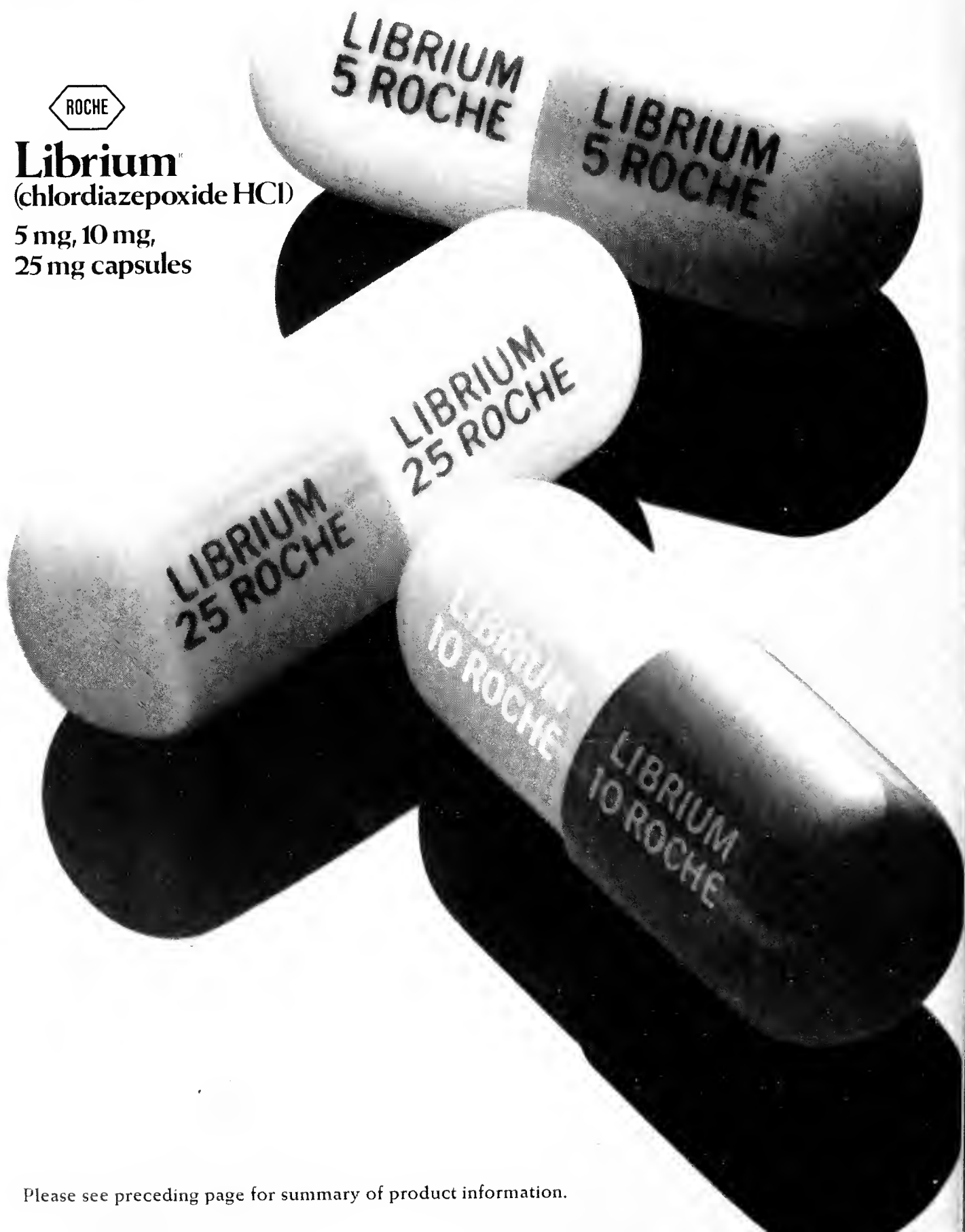
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Medical Journal

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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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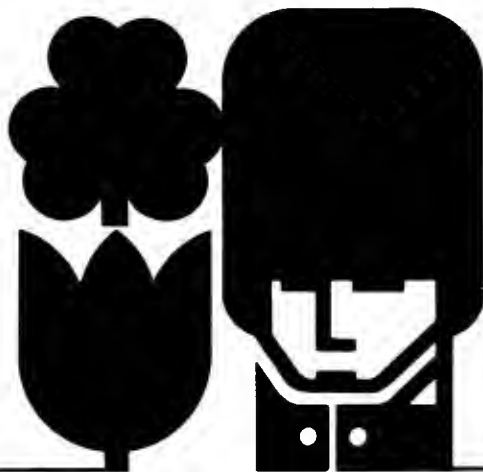
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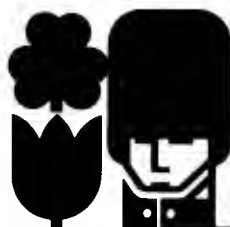
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The Epidemiologic Transition in North Carolina

During the Last 50 to 90 Years:

II. Changing Patterns of Disease and Causes of Death

Abdel R. Omran, M.D., Dr. P.H.*

THE application of certain principles of the epidemiologic transition theory to mortality data for North Carolina during the last 50 to 90 years has been published in the preceding paper, "The Epidemiologic Transition in North Carolina During the Last 50 to 90 Years: I. The Mortality Transition." In this paper, emphasis will be given to the changing patterns of health and disease as reflected by causes of death. This is a most significant component of the epidemiologic transition from high fertility and mortality to low fertility and mortality. The shift that occurs in these patterns triggers a chain reaction in mortality indices, life expectancy, patterns of health services required, and related social and administrative issues. Patterns of fertility, age and sex structure of the population, and even migration patterns also may be affected, either directly or indirectly. My intention is to characterize the transition in patterns of causes of death in North Carolina.

SHIFTS IN CAUSE-OF-DEATH PATTERNS

During the past 90 years in North Carolina profound changes have taken place both in disease patterns

and in causes of death. Although the early data are less reliable than data available since 1915, some indication can be gained concerning the magnitude of the toll that various categories of disease have claimed.

Figure 1 gives the deaths per thousand population for specified disease categories and shows that mortality from tuberculosis and other infectious diseases and mortality from diseases of early infancy declined markedly, whereas mortality from heart disease, cancer, vascular diseases of the central nervous system and violence has increased. The figure also gives the in-

dexed trend lines for these mortality rates, using the rates of 1920 as equivalent to 100. The relative changes are highest for heart disease among the ascending epidemics, while tuberculosis and infectious diseases describe a most significant decrease among the descending epidemics.

Considering the cumulative cause-of-death ratios given in Figure 2, it is clear that the percentage of total deaths due to tuberculosis and other communicable diseases was extremely high in 1880, amounting to 49 percent. In 90 years, the proportion has dropped to 6.1 percent. On the other hand, the proportion of

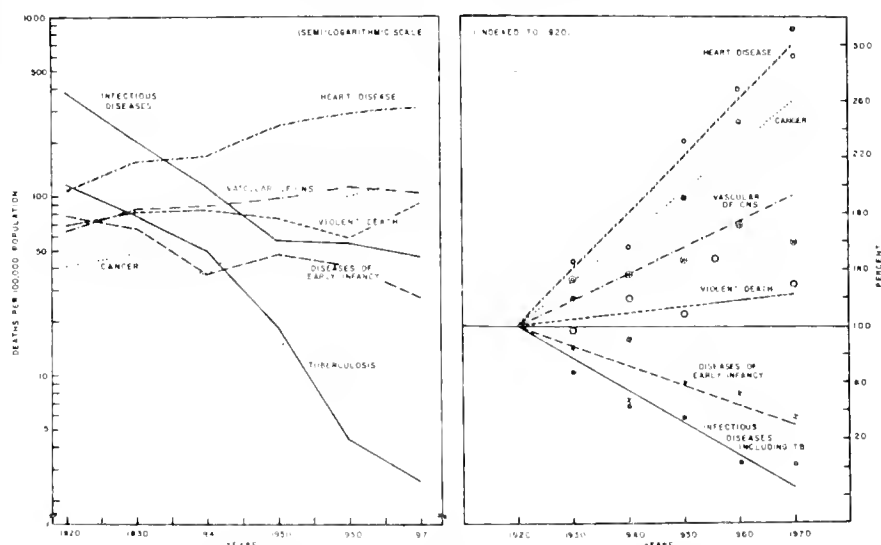


Fig. 1. Trends in major causes of death in North Carolina.

Sources: Calculated from data in *U.S. Vital Statistics, 1920-1969*; 1970 data are from North Carolina State Board of Health, *North Carolina Vital Statistics, 1970*.

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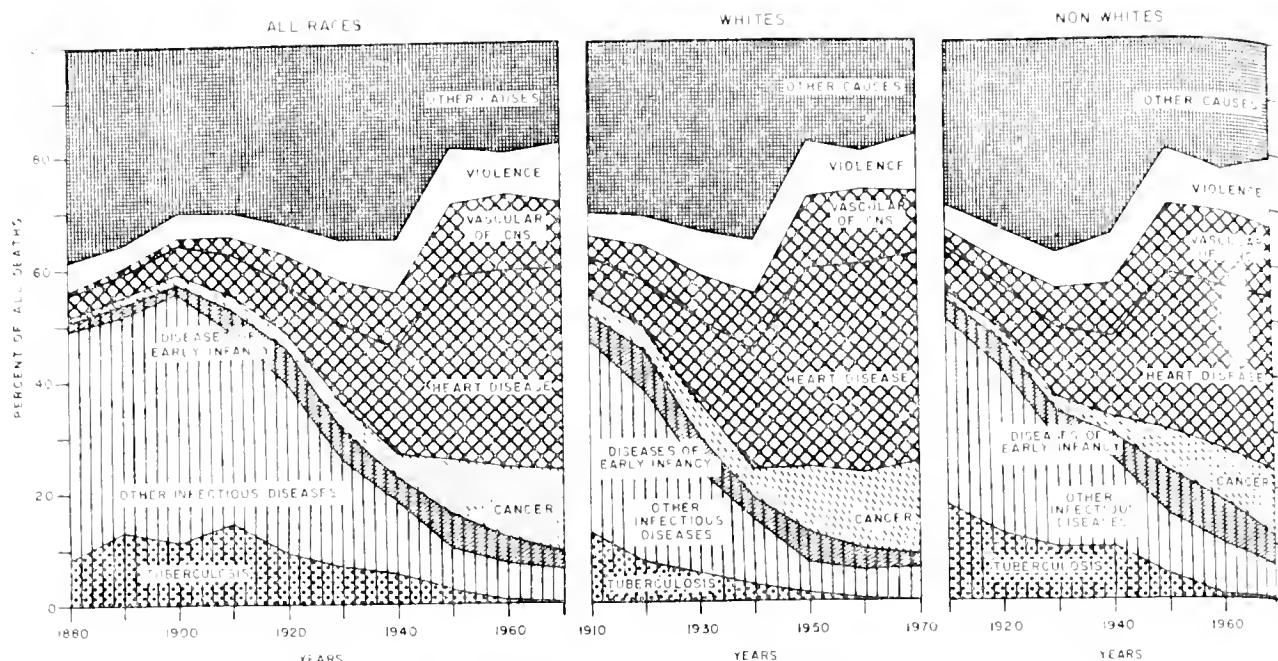


Fig. 2. Trends in cumulative causes of death ratio (percent) in North Carolina.

Sources: Same as Fig. 1.

deaths due to heart disease increased from 3.6 percent in 1880 to 35.8 percent in 1970. As for cancer, its proportional mortality increased from 1.1 percent in 1880 to 14.7 percent in 1970. Each race has had similar trends, but reliable data are available only for the period 1910-1970.*

The leading causes of death for each ten years from 1920 to 1970 are listed in Table 1. Although not included in these data, the leading causes of death in 1880 were tuberculosis, pneumonia, influenza, and other infectious diseases, as well as diseases of early infancy. Despite preventive and curative advances and social betterment, by 1920 pneumonia, influenza and tuberculosis were still the leading causes of death; two other categories of infectious disease had reached the top ten, namely, diarrhea/enteritis and puerperal causes. Diseases peculiar to early infancy occupied fifth position, heart disease was the third

leading cause, and malignant neoplasms were ninth.

By 1930, heart disease had already moved to the first position and malignant neoplasms to the sixth position, while three categories of infectious diseases (pneumonia/influenza, tuberculosis and diarrhea/enteritis) and one deficiency disease (pellagra) were among the ten leading causes of death.†

By 1950, the killers typical of modern societies — heart disease, vascular lesions of the central nervous system and malignant neoplasms — were already the top three of the ten leading causes of death; they have been there since, with malignant neoplasms moving into second place. Pneumonia/influenza has persisted as a leading cause of death throughout the period covered by the study, as have diseases of early infancy. After 1950, tuberculosis was displaced by diabetes as one of the ten leading causes of death.

Accidents of all types except motor vehicle have occupied an intermediate position on the list since 1920; in the 1930s, motor vehicle accidents began to appear as a separate leading cause of death and have been moving toward a higher position on the list.

SOME TRANSITIONAL PROFILES OF SELECTED DISEASES

Tuberculosis

Mortality from tuberculosis has undergone significant changes over the last fifty years. The decline in tuberculosis mortality is responsible for a large proportion of the decline in mortality from infectious diseases. In order to examine this point, the standardized mortality decline of specific infectious diseases as proportions of the total decline in infectious disease mortality was calculated, using one million population with the age distribution of the United States in 1940 for the standardization (Table 2). Between 1915 and 1970, 60 percent of the total decline in infectious disease mortality was attributable to the decline in tuberculosis mortality alone, 21.7 percent to diarrhea and dysentery, 9.5 percent to typhoid, 7.1 percent to pneumonia/influenza/bronchitis, 4.2 percent to selected childhood diseases, 4.0 percent to syphilis, and only 3.7 percent to malaria and smallpox. Some infectious diseases increased slightly during this period as indicated by the +12.3 percent of deaths attributed to other diseases.

Another feature in the pattern of

*Certain malignancies were responsible for most of the increase in cancer mortality: cancers of the respiratory tract, breast and genitourinary tract.

†Pellagra, a common disease in less developed countries, was prevalent in the southern United States in the early part of the twentieth century. In North Carolina, it was a principal cause of death until the 1930s and occasionally appeared as one of the ten leading causes of death.

tuberculosis mortality is the transition in the age curves over the years, (Figure 3). Early in the century, as late as 1920, the age-specific mortality rate described three peaks: a small peak in early childhood, an extremely high peak in adolescence and young adulthood, and an intermediate peak in old age. The risk of mortality from tuberculosis was much higher for non-whites than for whites, particularly in adolescence and young adulthood. Despite the decline at all ages that was noticed in 1940, the characteristic peaks and differentials were still noticeable, and the toll that the disease claimed among non-whites be-

tween ages 20 and 60 was unduly high. By 1970, however, the risk of mortality from tuberculosis had become almost negligible except for the age groups above 50 years, especially for non-whites. Even among these groups, the risk has been dramatically reduced.

Heart disease

Heart disease has been responsible for ever-increasing proportional mortality in North Carolina, especially within the past few decades. In 1970, for example, heart disease accounted for well over one-third of deaths. Differential mortality by sex and race between 1930 and 1970

is shown in Figure 4. For most of this period, white males sustained the highest rates (except for the period preceding 1940), followed by non-white males, then non-white females; the white female enjoyed the lowest mortality.

In regard to age (Figure 5), a very small peak occurs in early childhood, which may be clinically significant because it represents largely congenital heart diseases. Thereafter, the rates drop until age ten (more in 1970 than in earlier years) only to continue increasing progressively with age.

Cancer

The rise in cancer mortality from 12.1 deaths per 100,000 population in 1915 to 121.3 in 1970, a tenfold increase, is largely the result of greater numbers of deaths from certain types of cancer. The greatest increases occurred in cancers of the respiratory, digestive and genitourinary systems; small increases occurred in leukemia, breast cancer and cancer of the buccal cavity and pharynx (Figure 6). The white population had higher rates than non-whites for most types of cancer mortality except that of the genitourinary system.

It is also noticeable that a sex differential exists in the trends for certain types of cancer. For both cancer of the digestive system and cancer of the respiratory system (especially lung cancer), males have shown steadily higher rates since the 1930s than have females. This is particularly true for respiratory system cancers, in which rates for males rose from 1.3 per 100,000 in 1930 to 45.7 in 1970, while the same rates for females increased from 0.8 to 7.6 per 100,000 (Figure 7). This difference is probably due to more smoking among males.

Age-specific death rates describe the typical picture of extremely low rates below the age of 30, with sharp increases thereafter. As expected, the rates in recent years have been higher than in earlier years (Figure 8). During this period, a shift in mortality by race has occurred, moving from higher rates for whites in 1920 to higher rates for non-whites up to the age of 80 in 1970.

Table 1
Ten Leading Causes of Death, N.C., Every Ten Years
1920-1970

Rank	1920	Deaths per 100,000 Population	Rank	1950	Deaths per 100,000 Population
1	Pneumonia and influenza	217.2	1	Heart disease	242.8
2	Tuberculosis, all forms	116.1	2	Vascular lesions of CNS	92.4
3	Heart disease	101.8	3	Malignant neoplasms	78.3
4	Vascular lesions of CNS	83.9	4	Diseases peculiar to the first year of life	47.2
5	Diseases peculiar to the first year of life	78.1	5	Pneumonia and influenza	32.8
6	Nephritis, all forms	74.4	6	All accidents except motor vehicle	30.1
7	Diarrhea and enteritis	67.9	7	Motor vehicle accidents	27.0
8	Accidental deaths	50.5	8	Nephritis, all forms	20.1
9	Malignant neoplasms	39.3	9	Tuberculosis, all forms	18.4
10	Puerperal causes	31.5	10	Diseases of arteries (except coronary and CNS)	13.3
Rank	1930	Deaths per 100,000 Population	Rank	1960	Deaths per 100,000 Population
1	Heart disease	155.2	1	Heart disease	290.2
2	Pneumonia and influenza	110.1	2	Vascular lesions of CNS	113.6
3	Nephritis, all forms	103.6	3	Malignant neoplasms	98.6
4	Diseases peculiar to the first year of life	96.9	4	Diseases peculiar to the first year of life	41.5
5	Vascular lesions of CNS	95.6	5	Pneumonia and influenza	40.8
6	Tuberculosis, all forms	78.5	6	All accidents except motor vehicle	30.2
7	Malignant neoplasms	48.1	7	Motor vehicle accidents	27.6
8	Diarrhea and enteritis	43.1	8	Diseases of arteries (except coronary and CNS)	18.0
9	All accidents except motor vehicle	40.8	9	Diabetes mellitus	13.9
10	Pellagra	32.5	10	Congenital malformations	12.1
Rank	1940	Deaths per 100,000 Population	Rank	1970	Deaths per 100,000 Population
1	Heart disease	166.8	1	Heart disease	314.5
2	Nephritis, all forms	96.1	2	Cancer	128.9
3	Vascular lesions of CNS	88.9	3	Cerebrovascular disease	105.0
4	Pneumonia and influenza	75.4	4	Influenza, pneumonia, bronchitis, etc.	46.3
5	Diseases peculiar to the first year of life	65.6	5	Motor vehicle accidents	34.1
6	Malignant neoplasms	58.2	6	All other accidents	31.4
7	Tuberculosis, all forms	49.9	7	Diseases of early infancy	27.4
8	All accidents except motor vehicle	36.7	8	Diabetes	16.2
9	Motor vehicle accidents	28.4	9	Cirrhosis of the liver	12.4
10	Diarrhea and enteritis	17.3	10	Homicide	12.3

PS: Calculated from data in U.S. Vital Statistics, 1920-1969. 1970 data are from North Carolina Vital Statistics Reports.

Table 2

Standardized Mortality Decline from Infectious Diseases
Between 1915 and 1970 per 1,000,000 Population
(Age Standardized to the Distribution of 1940 U.S. Population)

Infectious Diseases	Expected Deaths* 1915 (a)	Expected Deaths* 1970 (b)	Difference (a - b)	$\frac{a - b}{T} \times 100$
1. Tuberculosis	534	23	511	60.0
2. Diarrhea and dysentery	209	24	185	21.7
3. Typhoid	81	0	81	9.5
4. Pneumonia, bronchitis and influenza	367	306	61	7.1
5. Selected childhood diseases	38	2	36	4.2
6. Syphilis	35	1	34	4.0
7. Malaria and smallpox	31	0	31	3.7
8. Encephalitis and meningitis	22	4	18	2.1
9. Other infections	25	130	105	12.3
Total	1,342	490	852	100.0

* Figures in columns (a) and (b) are standardized mortality figures obtained by applying the age-specific mortality rates of the particular disease to the standard population of 1,000,000 and taking the total (age standardized) deaths.

Sources: Calculated from data in U.S. Department of Commerce, U.S. Vital Statistics, 1915 and North Carolina Vital Statistics, 1970.

Diabetes

Diabetes has appeared as a leading cause of death in recent years. Besides the increase in incidence, changes have also occurred in age and race specific mortality from diabetes (Figure 9). In 1920, the rates were low for those under 45 years of age and lower for whites than for non-whites, whereas higher rates after the age of 45 showed white mortality higher than non-white.

By 1970, a shift occurred in

mortality by race for the older age groups, whereby non-whites had higher rates than whites after age 30. For both racial groups, the rates have increased substantially from the figures for 1920.

THE TRANSITION IN INFANT MORTALITY

Since infant mortality constitutes an important index of health, and accounts for a large proportion of

Fig. 5. Age specific mortality from heart disease in North Carolina, 1920-1940 and 1970.

Sources: Same as Fig. 3.

general mortality, an examination of its causes over time is in order. Most of the decline in infant mortality, attributable to the decline in death from prematurity, bronchitis/pneumonia influenza, diarrhea and er

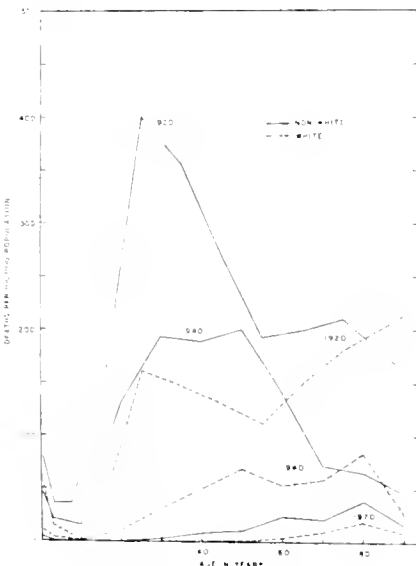


Fig. 3. Age and race specific mortality from tuberculosis in North Carolina, 1920, 1940, and 1970.

Sources: U.S. Department of Commerce, U.S. Vital Statistics 1920, 1940, U.S. Department of Commerce, U.S. Census Reports, 1920, 1940, and 1970; 1970 data from North Carolina Vital Statistics, 1970 (unpublished).

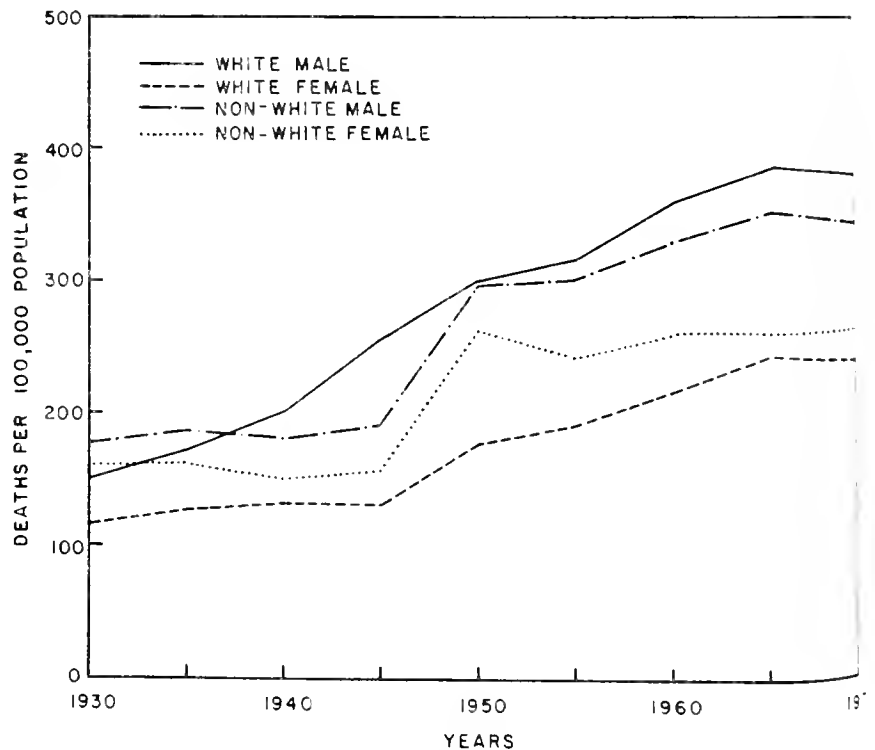


Fig. 4. Sex and race specific mortality from heart disease in North Carolina, 1930-1970.

Sources: Same as Fig. 3.

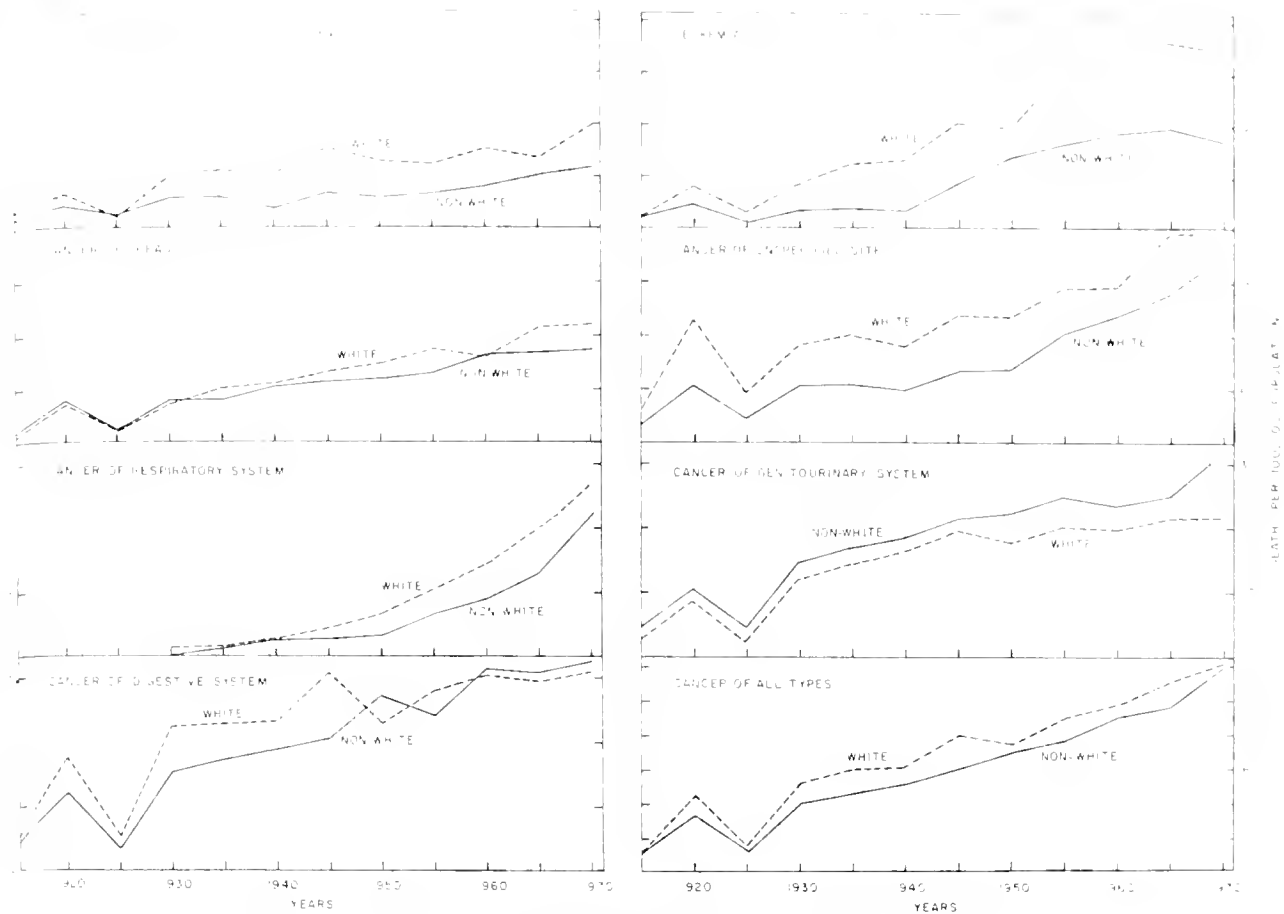


Fig. 6. Race specific mortality from various types of cancer in North Carolina, 1915-1970.

Sources: Same as Fig. 3.

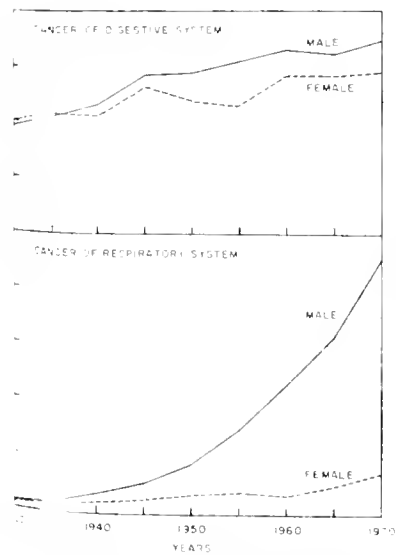


Fig. 7. Sex specific mortality from digestive and respiratory cancer in North Carolina, 1930-1970.

Sources: Same as Fig. 3.

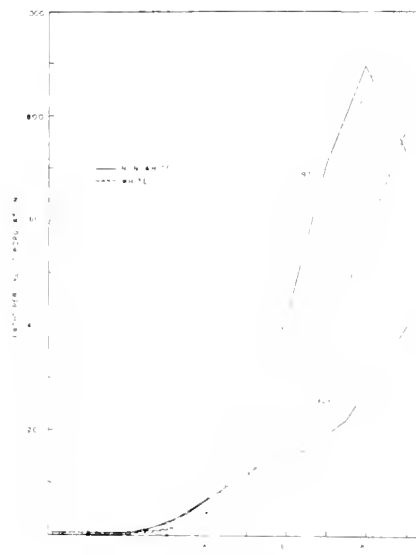


Fig. 8. Age and race specific mortality from cancer in North Carolina, 1920 and 1970.

Sources: Same as Fig. 3.

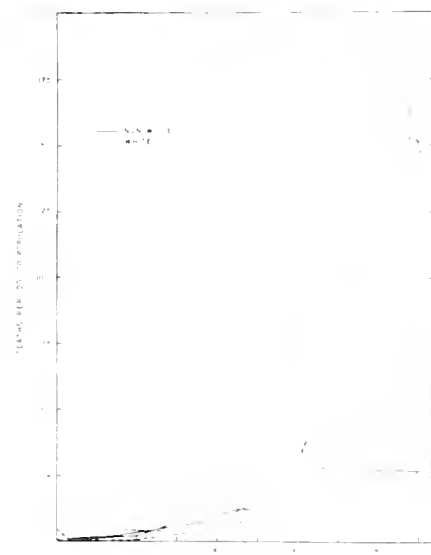


Fig. 9. Age and race specific mortality from diabetes in North Carolina, 1920 and 1970.

Sources: Same as Fig. 3.

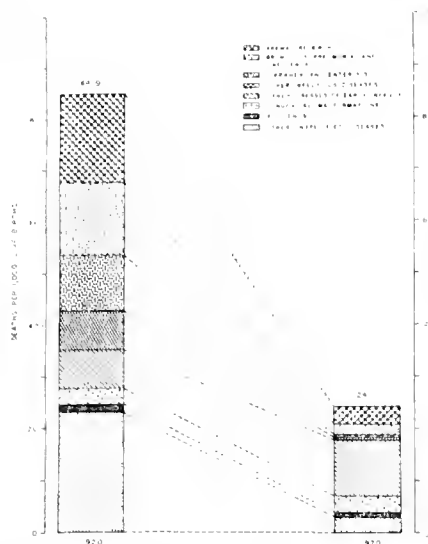


Fig. 10. Infant mortality by causes in North Carolina, 1920 and 1970.

Sources: U.S. Department of Commerce, U.S. Vital Statistics, 1920; N. C. Department of Health, N. C. Vital Statistics, 1920; 1970 data from unpublished *North Carolina Vital Statistics Reports*.

teritis, and other infectious diseases. Reductions in mortality from accidents and a number of other unspecified diseases have also occurred. On the other hand, death rates from congenital malformations have changed very little, and mor-

tality from a number of diseases of early infancy has increased slightly (Figure 10). Since most of the decline occurred in the post-neonatal period, the ratio of neonatal to total infant deaths increased (Figure 11). This evidence points to the increasing need for programs to combat neonatal mortality, so that it, too, may eventually decline.

CONCLUSION

From available data discussed in this report, it is obvious that North Carolina has been undergoing a vigorous epidemiologic transition from high to low mortality. During this transition, a significant shift has occurred in patterns of disease and death, whereby epidemics and epidemics of infectious diseases have receded substantially, while degenerative and chronic diseases, especially heart disease, cancer and vascular lesions of the central nervous system, have increased. Because of the shifts in age at death from childhood and young adulthood to older ages, a substantial increase in life expectancy was achieved. Typically, children and young adults have benefitted most from mortality decline, as have fe-

males in comparison with males. A racial groups have been affected by the trend toward lower mortality, although non-whites have had a relatively slower transition than whites. The transition is continuing, and further movement in mortality is expected.

The method of analysis as depicted in these papers is valuable for a better understanding of historical trends. Further, the nature and details of the epidemiologic transition should be carefully considered for predicting future trends, for projecting population profiles and, above all, for planning successful health programs.

ACKNOWLEDGMENT

I wish to thank three medical students (now physicians) who did some primary analysis in this area as part of a 1969 summer research program: Drs. James E. Kelly, James S. McFadden, and Joseph E. McCormick. Thanks are due to Anne Leung and Virginia Miller for compiling the information and preparing data, and to Jan McIntroy for editing and Nancy Perrin for typing.

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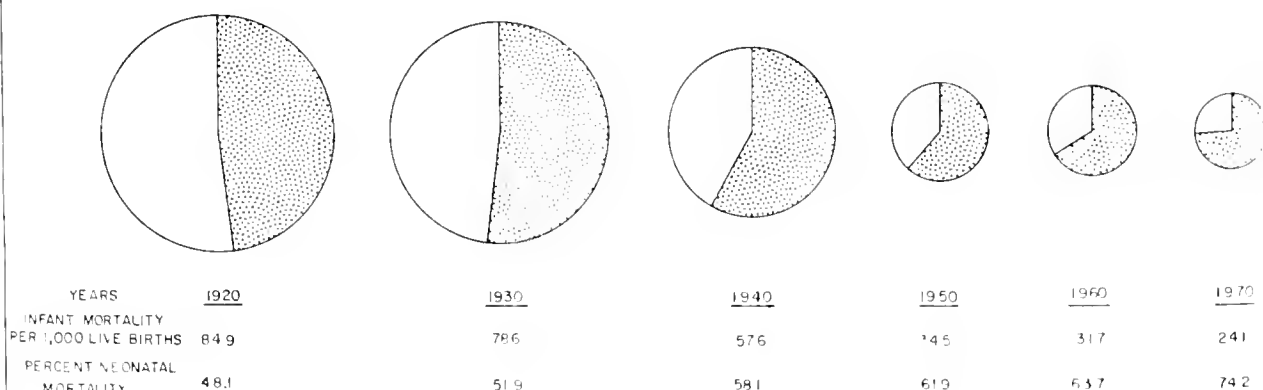


Fig. 11. Percent neonatal to total infant mortality in North Carolina, 1920-1970.

Sources: Same as Fig. 10

The Quality of Perinatal Care in North Carolina

Edward H. Bishop, M.D.,* and George W. Brumley, M.D.†

A COMPLETE evaluation of the quality of perinatal care would, necessarily, be multifactorial and require consideration of much information that is not readily available. Therefore, this review of the quality of perinatal care in North Carolina will be limited to a discussion of three key factors: (1) the prevalence of prenatal care, (2) the categories of personnel performing deliveries, and (3) the categories of medical personnel responsible for immediate care of the neonate.

It is a generally accepted obstetrical premise that the adequacy of prenatal care ranks high in importance among the many factors which can beneficially influence reproductive results. Advocates of this thesis also suggest that the quality of prenatal care is directly related to the number of prenatal visits by the patient. Therefore, the following question was included in the North Carolina Perinatal Services Questionnaire (described in previous publications) developed under the auspices of the Task Force on Maternal and Infant Care, Governor's Council on Comprehensive Health Planning^{1, 2}:

Estimate the prevalence of prenatal care for those patients delivered in your hospital (in 1962).

- a. 5 or more prenatal visits%
- b. 1 to 4 prenatal visits%
- c. 0 prenatal visits%

Although it is recognized that the answers obtained from this survey represent estimates only, an extrapolation of these estimates indicates that in 1972 (1) approximately 3,000 mothers in North Carolina received no prenatal care, and (2) prenatal care was inadequate for another 10,000, as judged by the physicians' reports that they received only one to four prenatal visits from those pregnant women. These conclusions illustrate a serious defect in the delivery of health care for the pregnant women of North Carolina. Although this defect may be partially a medical problem, it is also a result of numerous other equally important factors in-

cluding availability of services and facilities, economics and education and motivation of the patient. Whatever the causative factors may be, this high incidence of inadequate prenatal care represents a defect requiring prompt amelioration.

As shown in Table 1, this study also confirmed the reported effect of prenatal care on reproductive outcome. Those hospitals reporting that 15 percent or more of their patients received fewer than five prenatal visits also reported a mean perinatal death rate of 34 per 1,000 births. In contrast, those hospitals reporting that fewer than 15 percent of their patients had inadequate prenatal care also reported a more favorable perinatal mortality rate of 28 per 1,000 births. Figure 1 illustrates, by groups of hospitals characterized by the annual number of births and

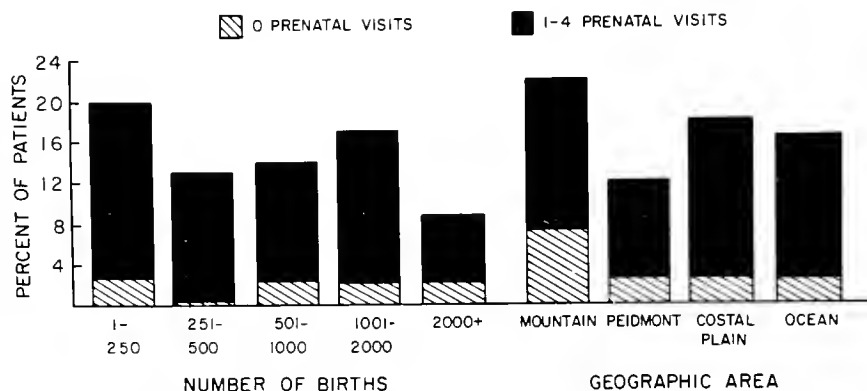


Fig. 1. Adequacy of prenatal care by annual number of births and geographic area.

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 †Associate Professor of Pediatrics, Duke University Medical Center, Durham, North Carolina 27710.
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Table 1

Perinatal Death Rates by Percent of Patients with Inadequate Prenatal Care

Percent of Patients with Inadequate Care	Death Rate	
	Fetal	Neonatal
20 percent or more	17.1	16.4
15 to 19 percent	15.5	19.6
14 percent or less	13.2	15.4

by geographic location, the percent of patients with inadequate prenatal care. The smaller institutions, most often located in rural areas, reported the highest prevalence of patients with less than adequate prenatal care. The western portion of the state reported the highest prevalence of patients with fewer than five prenatal visits. Although the percent of patients with inadequate prenatal care was lowest in the Piedmont area, the improvement in this aspect of care was not sufficient to improve outcome. As a result of the high concentration of the population in this area, a greater number of obstetrical patients had inadequate care in the Piedmont area than the combined total of all other areas of the state. The location of the larger obstetrical services and the inclusion of the majority of medical teaching centers, as well as the existence of a large ratio of specialists per unit population in this area, have not been sufficient to overcome this fault of medical care.

Distribution of deliveries controlled by the category of respon-

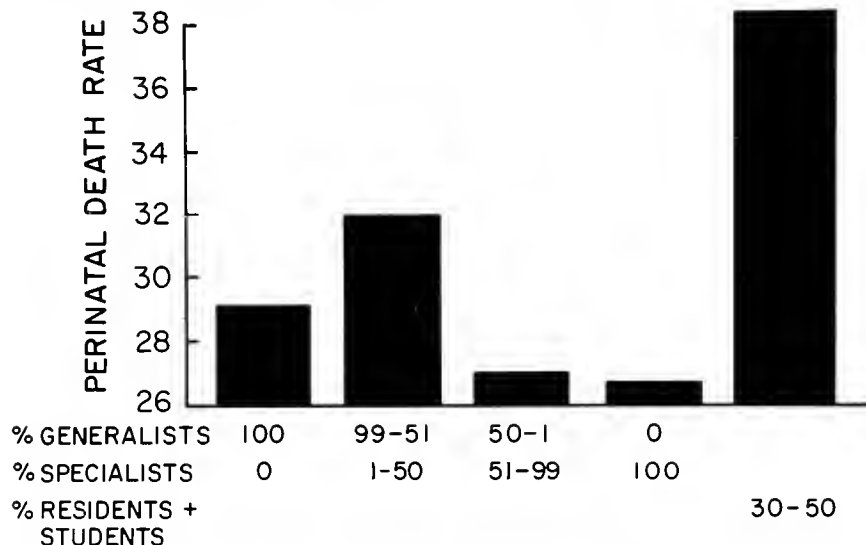


Fig. 2. Perinatal mortality rates by category of personnel performing deliveries.

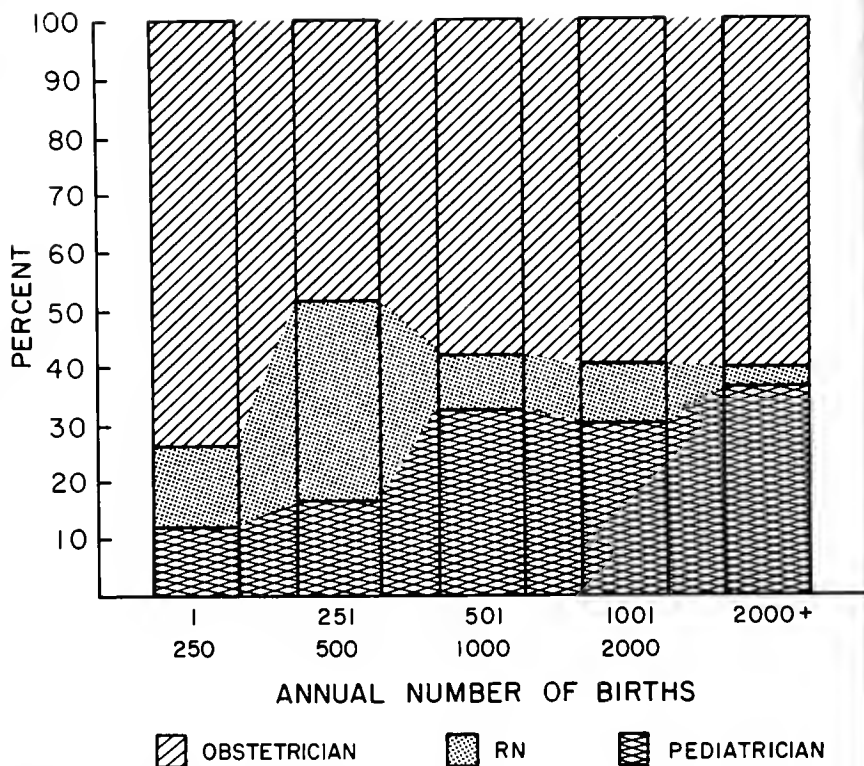


Fig. 3. Category of personnel responsible for infant resuscitation ("high risk").

sible personnel is shown in Table 2. The data for the entire country are based on the report of the National Study of Maternal Care, Survey of Obstetric Practice and Associated Services in Hospitals in the United States,³ and represent information collected for the calendar year 1968. Only minor differences in experiences are noted between North Carolina and the country as a whole, with a slightly higher incidence of deliveries by specialists and a lower

percent by physicians in training in North Carolina.

Perinatal mortality rates controlled by the various categories of physicians responsible for delivery are illustrated in Figure 2. The relatively high rates in those hospitals, in which 50 to 100 percent of the deliveries were performed by generalists, cannot and should not be attributed solely to the quantity of training or experience of the responsible physician. Characteristically, these hospitals are located in rural areas and maintain small obstetrical services which can neither afford nor justify maintenance of complete facilities and services. These institutions often serve a disproportionately large ratio of economically deprived patients who are often in "high risk" categories. Only too of-

Table 2
Category of Personnel Performing Deliveries

Category	Percent	
	N.C.	U.S.
Specialist	64	51
Generalist	29	31
Resident, interns, students	7	17
Other	0	1

in these areas consultation services cannot be easily obtained.

The high perinatal mortality rate at those centers participating in the training of physicians cannot be attributed to the fact that in these institutions 30 to 50 percent of the deliveries were performed by students, interns or residents. Many high-risk mothers and infants are referred to these teaching institutions and, therefore, a disproportionately high incidence of unfavorable outcomes can be expected. This observation is true not only for North Carolina, but for all other areas of the country as well.⁴

The first few minutes or hours of life are the most perilous and during this time the quality of life for the survivor is significantly influenced by the quality of care. Therefore, this period justifies and demands the most expert attention and management. In an attempt to evaluate the quality of care during this dangerous period the following question was included in the perinatal services questionnaire: "Who was responsible for the resuscitation of the

expected normal infant and the high-risk infant?" The results illustrated in Figure 3 represent an additional defect in our current system of perinatal care.

The solution to this latter problem is indeed difficult. The delivering physician should not be asked to simultaneously divide his attentions between the mother and the newborn during this critical period. The delivery room nurse is not ordinarily adequately trained to accept responsibility for independent care of the neonate. A nurse anesthetist may be more adequately trained and experienced in resuscitation, but attention of these individuals should be directed to the mother. Pediatricians are too few and too busy to be able to attend each delivery. Even if their attendance was universally possible, an increased economic burden would be added to the already great cost of births. Only the largest or most sophisticated hospitals can expect to have a neonatologist available for immediate care of the newborn. The only solution which appears both feasible and practical

is the amalgamation of smaller, less efficient obstetrical services and the gradual, but progressive, regionalization of perinatal services. Only such an action can overcome the current obstacles.

We, the physicians and the citizens of the state face a dilemma — the dilemma of selecting the best method by which we can improve the quality of reproduction. The final solution may require a change in our system and a sacrifice of local pride, as well as some inconvenience to the individual physician. In spite of these seemingly difficult obstacles, change, with an anticipated resultant improvement, is urgently needed. Regionalization of perinatal care seems to offer a possible method of attaining such beneficial change.

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If we could only raise the standard of education, preliminary & college, of our students, & make gentlemen of them all, how happy we both should be! The miserable wretches who now degrade our Schools, unwashed, with dirty nails, unkempt hair, slouched hats, with their hands in their pockets when they meet or pass a professor, are a disgrace to the profession, & injure the whole leven. Surely there ought to be a remedy for all these crimes! Surely these animals ought to be kept out of a noble profession! If we could only have honest, competent boards of examiners, there might be some hope, but, as matters now are, there is no prospect of amelioration, no hope of improvement.—*Letter from Samuel D. Gross, M.D. to J. M. Toner, M.D., Jan. 2, 1875 quoted in Bell, W.J. "Joseph M. Toner as a Medical Historian," Bull Hist Med 47:1-24, 1973.*

The Placement Service of the North Carolina Society of Anesthesiologists

Joseph F. Patterson, Jr., M.D.

IN 1968 the North Carolina Society of Anesthesiologists began a Placement Service for anesthesiologists who desired to locate or relocate in North Carolina. The need for such a service is underscored by 1970 statistics which showed North Carolina to rank 48-49 among the states in resident anesthesiologists per 100,000 population.^{1, 2}

FORMATION OF THE SERVICE

A Placement Service Committee composed of eight members — four anesthesiologists in private practice in North Carolina and four full-time members of anesthesiology departments of the medical schools in the state—were empowered to investigate existing services and to make recommendations.

Other states' placement services contacted by the Committee had no organizational guidelines, and the guidelines of the Placement Service of the American Society of Anesthesiologists, were thought inappropriate by the Committee for use on a state level.

In May 1969, the Committee

¹From the Department of Anesthesiology, School of Medicine, University of North Carolina, Chapel Hill 27514.

Placement Service North Carolina Society of Anesthesiologists

Date: _____

1. Name: _____ Age: _____ Sex: _____

2. Present Address: _____

3. Telephone Number Home: _____ Hospital: _____

4. Married? _____ Number of Children _____

5. Citizen of U.S.A.? Yes _____ No _____ If no, have you passed E.C.F.M.G. examination? Yes _____ No _____

6. Academic college degree from: _____ Date: _____

7. Medical degree from: _____ Date: _____

8. Internship at: _____ From: _____ To: _____

9. Anesthesia Residency:

Institution	Address	Dates
_____	_____	_____
_____	_____	_____

10. Licensed to practice in what State or States? _____

Remarks: _____

11. Membership in ASA? Active _____ Junior _____ Other _____

12. Diplomate of American Board of Anesthesiology? Yes _____ No _____ Board eligible? Yes _____ No _____

13. Fellow of The American College of Anesthesiologists? Yes _____ No _____

14. Type and location practice desired: _____

15. Permission to disclose your name and above information to individuals, groups, or hospitals in North Carolina seeking the services of an anesthesiologist? Yes _____ No _____

Signed _____

Mail to:

Placement Service
North Carolina Society of Anesthesiologists
Department of Anesthesiology
North Carolina Memorial Hospital
Chapel Hill, North Carolina 27514

Fig. 1. Physician Information Form.

Placement Service
North Carolina Society of Anesthesiologists

Date: _____

Name of City: _____ Population: _____ Name of County: _____

Name and address of hospital or individual seeking anesthesiologist: _____

Size of hospital: _____ beds

INDIVIDUAL TO CONTACT:

Type hospital:

Name _____

A. Teaching?

Address _____

B. Non-teaching?

Training program:

A. Approved Residency?

B. None?

Position in Hospital

Are you seeking an anesthesiologist:

(Administrator, Surgeon, Anesthesiologist, etc.)

A. To direct a department?

B. As an associate?

Telephone Number

C. As a partner in group practice?

Hospital or Office

D. Individual practice?

Home

E. Other?

Source of income?

A. Fee for service?

B. Salary from group?

C. Other? Details: _____

Permission to disclose your name and above information to anesthesiologists interested in locating or relocating in North Carolina? Yes _____ No _____

Signed _____

Mail to:

Placement Service
North Carolina Society of Anesthesiologists
Department of Anesthesiology
North Carolina Memorial Hospital
Chapel Hill, North Carolina 27514

Fig. 2. Location Information Form.

impart information requested.

5. That the Placement Service be established primarily for members of the American Society of Anesthesiologists, but that its services be available to other qualified anesthesiologists.

(a) That the Committee chairman determine qualifications and consult other Committee members in questionable cases.

These proposals were approved at the 1969 annual business meeting of the North Carolina Society of Anesthesiologists. The inquiries suggested that anesthesiologists were needed in some 20 communities.

MEETING THE NEED

In 1969 few anesthesiologists expressed interest in coming to North Carolina. However, the North Carolina Medical Society supplied the names of seven anesthesiologists listed with its Placement Service, and several more were obtained from the American Society of Anesthesiologists Placement Service. In 1970 advertisements placed in *Anesthesiology* (September) and *Anesthesia and Analgesia* (November-December) and notices concerning the Placement Service in the NORTH CAROLINA MEDICAL JOURNAL elicited numerous replies from anesthesiologists in the United States and other countries.

The communities listed with the new North Carolina Society of Anesthesiologists Placement Service are advised to list also with the Placement Service of the American Society of Anesthesiologists.

In 1973 residents participating in the anesthesiology training programs in North Carolina were urged to list with the Placement Service.

In the fall of 1973 the Division of Education and Research in Community Medical Care of the School of Medicine of the University of North Carolina contacted residents in approved residency training programs in all specialties in 14 mid-Atlantic and southeastern states. They were sent information about North Carolina and asked whether they would be interested in practicing here. Of approximately 590 affirmative replies 30 came from anes-

make the following recommendations which were approved by the Society at its annual business meeting:

1. That the Placement Service's central file be located at the Department of Anesthesiology, University of North Carolina School of Medicine, Chapel Hill.

2. That simplified forms be used to obtain information from anesthesiologists (Figure 1) and from localities seeking anesthesiologists (Figure 2).

3. That the state's needs for anesthesiologists be defined by sending Location Information Forms to:

a) Members of the North Carolina Society of Anesthesiologists.

b) Surgeon(s) in every community large enough to need anesthesiologist(s).

(c) County Medical Society presidents.

(d) All hospitals in North Carolina holding membership in the North Carolina Hospital Association.

4. That the Placement Service assist persons or communities in North Carolina seeking such a specialist and anesthesiologists desiring to locate or relocate in the state.

(a) That information be provided each party asking (Figures 1 and 2).

(b) That information concerning locations be furnished the requesting anesthesiologist.

(c) That information about anesthesiologists be furnished interested persons and hospitals.

(d) That permission be obtained from persons and hospitals listed to

A file is started for each community and anesthesiologist contacting the Service. A form letter and Location Information Form are sent to each location, and a similar letter and Physician Information Form to each anesthesiologist seeking assistance. The information obtained is provided each active party. When a community lists initially, data concerning the anesthesiologists actively listed are pro-

ANESTHESIOLOGISTS INTERESTED IN NORTH CAROLINA

AREAS IN NEED OF ANESTHESIOLOGISTS

Fig. 4. Placement Service Board.

vided with an accompanying letter (Figure 3) and contact maintained. Likewise, the anesthesiologist is provided with information concerning the active locations when he lists initially.

Current status is recorded on a board listing anesthesiologists and communities (Figure 4). In addition, a map of North Carolina, conspicuously placed for out-of-state visitors, is used to show communities needing an anesthesiologist.

Every six months questionnaires are mailed to all locations and anesthesiologists on the active lists to determine whether they wish to continue their listing on the Placement Service, and a self-addressed, stamped postcard enclosed.

RESULTS

Communities

Since the inception of the Placement Service, 43 areas have listed, the majority being community hospitals, but including the three medical school training programs and anesthesiologists in private practice seeking associates: 19 areas are now listed as seeking anesthesiology assistance; 15 have gained the services of one or more anesthesiologists through the Placement Service; 24 formerly listed with the Service are on an inactive status; several obtained anesthesiologists outside the Placement Service; and others decided that the need for an anesthesiologist did not exist (Table 1).*

Anesthesiologists

One-hundred thirty-three anesthesiologists, representing 27 states and four foreign countries, have contacted or been contacted by the Placement Service since 1969. Forty-two are on the active roster, representing 17 states and one foreign country. Ninety-one are inactive (Table 2). The number of anesthesiologists contacting the Service has fluctuated from year to year (Table 3). Florida, North Carolina and New York have the largest

Table 1
Areas Expressing Need for Anesthesiologists by Listing with Placement Service

Areas on present active list	19
Areas now inactive	24
Decided no need existed	7
Obtained own anesthesiologist	4
Staffed by placement service applicants	13*
Total	43

* A total of 15 areas have been staffed by Placement Service applicants. Two of these areas remain on the active list. Three areas have obtained more than one anesthesiologist through the Placement Service.

number of applicants (Table 4).

Eighteen anesthesiologists have located or relocated in North Carolina through the efforts of the Service—seven from North Carolina and 11 from five other states and one foreign country (Table 5). Of the 16 anesthesiologists who located here, five joined the staffs of the anesthesiology departments of the medical schools. The others entered community private practice. Six of the 16 anesthesiologists who located in the state received their anesthesiology training in North Carolina. Four entered practice upon completing their residencies, and two returned to North Carolina upon completion of military service.

Of the 133 anesthesiologists who have contacted the Service, 70 have been anesthesiology residents in training. The greatest number, 28, listed in 1973 (Table 3). Of the 42 persons on the active list, 29 are residents (Table 4); seven of them are in their first year of training, 17 in their second year, and five in the third year (Table 6). These listings

Table 2

Number of Anesthesiologists Who Have Contacted or Been Contacted by the Placement Service

Number on present active list	42
Number now inactive	91*
Located in North Carolina	16†
Relocated in North Carolina	2
Located elsewhere	20
Remained at present location	8
No return of physician information form	33
No reply to follow-up questionnaire	12
Total	133

* Two are deceased.

† One has returned to his former location.

evidently reflect (1) the efforts of the Placement Service to encourage residents in North Carolina anesthesiology training programs to avail themselves of the Service, and (2)

Table 3

Total Number by Year of Anesthesiologists and Anesthesiology Residents Who Have Contacted or Been Contacted by the Placement Service

Year	Total No.	No. Residents in Training
1969	4	1
1970	25	6
1971	16	4
1972	21	9
1973	41	28
1974*	26	22
	133	70

* Through May 15.

Table 4

Present Location of Anesthesiologists on Active List of Placement Service and the Number who are Anesthesiology Residents in Training

Present Location	Total No.	No. of Anesthesiology Residents in Training
Florida	9	9
North Carolina	5	5
New York	5	4
Ohio	3	1
Virginia	3	2
Kentucky	2	1
Massachusetts	2	1
New Jersey	2	0
Tennessee	2	1
Other States (8)	8	5
India	1	0
Total	42	29

Table 5

Former Areas of Residence of Anesthesiologists Who Have Located or Relocated in North Carolina through Efforts of the Placement Service

Former Area of Residence	No.
North Carolina	7
Anesthesiology residents following completion of training in North Carolina	5
Relocation of anesthesiologists in private practice in North Carolina	2*
Florida	4
New Jersey	2†
Georgia	2
Ohio	1
Wisconsin	1
England	1
Total	18

* One is deceased.

† One returned to New Jersey.

* Data in tables include statistics through May 15, 1974. Subsequently four additional areas have obtained anesthesiologists through the efforts of the Placement Service.

Table 6
Level of Training of Anesthesiology
Residents on Active List of
Placement Service

Year of Residency	No.
1st	7
2nd	17
3rd	5
Total	29

the contacts which have been made by the Division of Education and Research in Community Medical Care of the University of North Carolina School of Medicine with anesthesiology residents throughout the southeastern and mid-Atlantic states.

In evaluating the Placement Service's role in helping satisfy the needs of North Carolina, it is interesting that as of December 31, 1968, there were 56 active members of the North Carolina Society of Anesthesiologists. As of May 31, 1974, the number of active members had increased to 106. As eight members listed in 1968 are not on

the 1973 roster, 58 anesthesiologists have established practices in North Carolina during this period. Of the 15 anesthesiologists who have located in North Carolina as a direct result of the Placement Service, ten are included in this group, and five have not yet joined the North Carolina Society of Anesthesiologists. One anesthesiologist who located in North Carolina through the efforts of the Service has since relocated in another state.

These statistics indicate that, since 1968, efforts of the Placement Service of the North Carolina Society of Anesthesiologists have increased the number of practicing anesthesiologists in North Carolina by approximately one-fourth. They also show that during this time there were many opportunities for anesthesiologists in the state of which the Placement Service was unaware.

Despite the remarkable increase in numbers of anesthesiologists who have located in the state since 1968, North Carolina probably has a greater need for anesthesiologists

than is indicated by the 19 active areas listed. Three areas have obtained more than one anesthesiologist through efforts of the Placement Service. Likewise, several areas on the present active list are seeking the services of more than one anesthesiologist.

The increasing numbers listed, particularly of residents in training (Table 3), may indicate that more anesthesiologists will locate in North Carolina.

The Service functions efficiently utilizing the part-time duties of one anesthesiologist and one secretary.

ACKNOWLEDGMENT

The author wishes to express his appreciation to Mr. John A. Payne and Mrs. Janet B. Francis, Division of Education and Research in Community Medical Care, University of North Carolina School of Medicine, for their past and continuing assistance in solving the need for anesthesiologists in North Carolina.

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An Englishman, Colonel Townshend, asserted that he could arrest the movements of his heart for half an hour. Cheyne relates that this Colonel, who had been ill a long while, took it into his head one day to send for Drs. Cheyne and Baynard, who were in attendance upon him, and for Mr. Skrine, his apothecary, to beg them to witness a singular experiment which he was anxious to repeat in their presence; it was to cause himself to die and to return to life. The patient lay on his back; Dr. Cheyne kept his finger on the pulse, Dr. Baynard placed his hand over the heart, Mr. Skrine held a mirror before the mouth. Shortly after, no arterial pulsation or cardiac movement could be felt, and the breath did not dim the glass. This spectacle having lasted for more than half an hour, the spectators were about to withdraw, persuaded that the patient had pushed his experiment too far, when they perceived some movement, then they felt the beats of the pulse and of the heart return by degrees, and respiration recommenced; in time the patient began to speak, and left the spectators equally astonished at his death and resurrection. When they had gone away, the Colonel sent for his attorney, added a codicil to his will, and expired peaceably eight hours after the experiment.—*Death and Sudden Death*, P. Brouardel, 1897, pp. 27-28.

Massive Hemorrhage From Multiple Gastric Ulcers in the Newborn: A Case Report

Charles W. Smith, Jr., M.D.*

GASTRIC or duodenal ulceration in the newborn and neonatal period is a difficult problem and is often fatal. Leix and Greaney¹ report 29 cases of which 22 were fatal. A serious illness usually precedes the onset, as in the series mentioned above in which only two patients were without prior disease. The most commonly associated conditions are sepsis, intracranial hemorrhage, intracranial neoplasm, generalized or local birth trauma, cutaneous burns, steroid therapy, and hypoglycemia.¹⁻⁵ These "stress type" ulcers are usually single, but occasionally are multiple.^{1, 2, 6-9} They most often develop in the first or second part of the duodenum but may also be in the body of the stomach.

The difficulty in making the diagnosis lies in the absence or vagueness of presenting signs and symptoms. Spencer¹⁰ noted that of 158 cases, melena preceded hematemesis in 11. Lannon and Sorour¹¹ emphasized that hematochezia, rather than melena, is common in infants with massive upper gastrointestinal bleeding. Thus, the classical localizing features of gastrointestinal bleeding are unreliable in this age

group. The diagnosis is usually made at the onset of such complications as hemorrhage or perforation.^{1, 12}

CASE REPORT

A newborn Caucasian boy weighed 7 lb. 11 oz. at birth and was the product of an uncomplicated gestation, labor and delivery. There was no family history of peptic ulcer disease or medication, except that iron and aspirin had been taken occasionally by the mother. There were no children previously. The baby's Apgar score was seven at one minute and eight at five minutes, and he had a weak cry. At 31 hours of age he had an initial episode of hematemesis. Laboratory studies at that time showed a hematocrit value of 55 percent and a platelet count of 265,000. Blood glucose was 48 mg/dl. An Apt test confirmed the blood to be fetal in origin. A nasogastric tube was passed with the evacuation of approximately 100 ml of bright red blood. Prothrombin, partial thromboplastin, and total clotting times were normal. At 36 hours of age his hematocrit value had fallen to 35 percent. For the next several hours 175 ml of whole blood representing 60 percent of the estimated blood volume was transfused to maintain a hematocrit value of 40 percent. During this time he continued to return fresh blood

following ice water lavage. At 40 hours of age he passed a large, dark, tarry stool. No bloody stools had been noted prior to this one. Because the hemorrhage was life-threatening, celiotomy was performed at approximately 41 hours of age.

The abdominal viscera were in their normal position and free peritoneal fluid was not increased. The stomach and small intestine were distended. Otherwise, the stomach and duodenum appeared normal externally. There was no external evidence of gastric or duodenal ulcer. An anterior gastrotomy was made from the midanterior stomach to the pylorus. Several clots of blood were removed from the stomach, and the incision was continued through the first part of the duodenum. Inspection of the stomach and duodenum revealed five foci of ulceration involving the corpus, measuring approximately 0.2 cm in diameter and exposing the underlying muscularis mucosa. They were oversewn with 6-0 chromic interrupted sutures. Although no other ulcers were found, the mucosa was friable and became edematous and hemorrhagic upon the slightest manipulation. A piece of mucosa was taken from the mid-stomach region for microscopic study. The gastrotomy was closed obliquely to effect a pyloroplasty, and the proximal end was used for a

From the University of North Carolina School of Medicine, Chapel Hill, North Carolina 27514.
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temporary gastrostomy site. A No. 14 Foley catheter was left in the stomach and brought out through a separate stab wound. The balloon was inflated to 3 ml and secured against the stomach wall. The left vagus nerve was divided but the right vagus was left intact because of the difficulty in identifying it. The patient tolerated the procedure well.

Postoperatively, there was no further bleeding. There were two or three tarry stools, the last on the second postoperative day. The hematocrit value remained stable at 40 percent. Oral feedings of five percent Dextrose were begun two days postoperatively and were tolerated well. There was no free gastric acid at this time. The baby began taking formula without difficulty on the fifth postoperative day. Stools were then benzidine negative. The gastrostomy tube was removed on the eighth postoperative day. The biopsy revealed an acute ulcer, exposure of the underlying muscularis mucosa, some areas of hemorrhage, but no signs of inflammation. The patient was discharged ten days after the operation. At that time he was eating a normal diet and gaining weight. When he was seen two months later he was asymptomatic.

When confronted with an infant who has gastrointestinal bleeding, the physician must consider many possibilities as to the cause. Of 158 patients under 12 months of age, Spencer¹⁰ reports that anal fissures are the most common cause, then intussusception, gangrenous bowel, duodenal ulcer, gastric ulcer, Meckel's diverticulum, duplication of the bowel, and hematoma eroding the ileum, in that order. Rare causes include hemangioma, enterocolitis, esophageal varices, arterio-mesenteric occlusion, benign tumor of the small intestine, and spontaneous bowel perforation.^{13, 14}

Although the cause of acute ulceration in the newborn is unknown, many intriguing theories exist. In infants subjected to stress, Foltz¹⁵ invokes factors playing on the limbic lobe of the brain which cause parasympathetic predominance via anterior hypothalamic and vagal nerve stimulation and hormonal

secretion via the posterior hypothalamic - pituitary - adrenal axis. Both of these pathways combine to increase stomach secretion of acid. A vascular hypothesis is proposed by Gius et al,¹⁶ Boyle et al,¹⁷ and Womack,¹⁸ who have found anomalies which occur more frequently in ulcer patients than in controls. This is an unlikely cause in infants, however, since they do not exhibit an ulcer diathesis in later life.¹⁴ Most authors feel that the relative gastric hyperacidity of newborn infants plays a significant role.¹⁹ There is a two- to threefold increase in parietal cell mass per unit area in newborns.^{12, 20} Within 24 hours after birth the gastric pH in 260 infants averaged 1.45.¹⁴ Within seven to eight days the hyperacidity disappears and reaches hypochlorhydric levels relative to those of adults.¹² This process can be understood in part by Polacek's and Ellison's²⁰ finding that there is an absence of parietal cell mitosis in infants. They also postulate that the increased acid levels are transient since they are related to hormonal influences in the mother during the last trimester of pregnancy. Adult levels of acid secretion are not regained until five to seven years of age.^{12, 20, 21} Another hypothesis suggests that the combination of relatively deficient gastric musculature in the newborn, producing a tendency to slow gastric emptying, with resulting distention of the stomach, may predispose him to perforation.²² In addition, it is suggested that this distention may cause increased gastrin levels in neonates, and thus may be a factor in gastric ulceration.¹⁴

Whenever possible, it is desirable to obtain radiologic studies prior to surgery. The difficulty of interpreting gastrointestinal roentgenograms in infants is attributed to the great variability in shape and degree of distention. The stomachs of neonates empty more slowly than at any other time in life. The roentgenographic signs of ulcer are the presence of either a niche in the stomach or duodenum or a deformity in the duodenum caused by scarring and cicatrix formation.¹⁴

Although conservative therapy is preferred when possible, the need for early celiotomy in life-threatening conditions is emphasized.⁵ Surgery is indicated in cases of massive hemorrhage or perforation.²³ Since, in contrast to the adult, these patients are not prone to recurrent ulceration, the objective of surgical treatment is to control the bleeding. This treatment usually can be accomplished by suture plication of the ulcer. Rarely is partial gastrectomy necessary, and several studies have shown that patients had normal growth and development after this procedure.^{14, 24} Vagotomy and pyloroplasty are not ordinarily indicated for these patients since there is no increased incidence of peptic ulcer formation in later life. In an effort to reduce mucosal blood flow, we considered vagotomy for the patient in this case because of the diffuse character of gastritis.

SUMMARY

1. Peptic ulcers of the stress type occur in newborns, and are discovered only after complications develop.
2. Ulcers in the newborn are usually associated with a preceding serious illness, but may occur in otherwise healthy children.
3. The need for early celiotomy is emphasized in life-threatening cases of perforation or massive hemorrhage.
4. Several etiologic theories are reviewed, such as stress-invoking "parasympathetic predominance" and the relative gastric hyperacidity of the newborn period.

ACKNOWLEDGMENT

I wish to thank Dr. Colin Thomas, Chairman and Professor, Department of Surgery, University of North Carolina School of Medicine, for his valuable assistance with this paper.

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We might definitely choose some sign as a distinction between life and death, and use it in a conventional way; but I am very much afraid that, however elastic this convention might be, whatever sign might be proposed to denote the moment of death, this sign and this convention will always remain useless in doubtful cases, and we are obliged to acknowledge that we have no sign or group of signs sufficient to determine the moment of death with scientific certainty in all cases.—*Death and Sudden Death*, P. Brouardel, 1897, p. 29.

Editorials

PROFESSIONAL LIABILITY. WHAT NEXT?

At the September 29, 1974 meeting of the Executive Council of the Society, the recommendation of the Committee on Professional Insurance that the request of The St. Paul Fire and Marine Insurance Company for an increase of 82.3 percent in rate for professional liability coverage was unanimously approved. Dr. Frank R. Reynolds, president of the Society, explained this position at hearings of Mr. John Ingram, North Carolina Commissioner of Insurance, December 11, 1974, and also submitted concurring view of Mr. John L. Glenn, accounting actuary retained by the Society to evaluate The St. Paul request. On December 19 Mr. Ingram, although disagreeing with the filing of St. Paul, entered a temporary order allowing a rate increase "effective for new and renewal business on January 1, 1975, but only for the period through and ending June 30, 1975." He further recommended action by the General Assembly relating to "terminations and cancellation of essential insurance."

Although the increase will still leave the rate for North Carolina physicians among the lowest in the nation, it is symptomatic of what can only be described as a crisis in medical malpractice insurance, which has led to dramatic rises in rates reflecting inflation, unprecedented numbers of claims and higher and higher court awards. As a result, several insurance companies have withdrawn from the field and several states, particularly New York, Maryland and Michigan, have problems almost beyond definition. For example the New York insurance department has resorted for the first time to the state's Unfair Insurance Practices Act in an attempt to force continued service by carriers because a proposed rate increase would result in family practitioners paying more than \$10,000 annually in malpractice premiums, compared to about \$3,500 previously. Alarmed that such a deteriorating financial situation may endanger effective medical practice and aggravate pre-existing deficiencies in health care, Caspar W. Weinberger, Secretary of Health, Education and Welfare, has indicated that the government is preparing plans for federally sponsored coverage for physicians whose insurance is cancelled and will seek and encourage appropriate measures to relieve the crisis.

Why then, with expanding medical knowledge which has made cardiac surgery and organ trans-

plantation almost prosaic because of improvements in anesthesia, continuing advances in immunology and more effective antibiotics for the treatment of infectious disease, are we faced with such difficulties? Is such a paradox the natural consequence of rising expectations allied with a quest for certainty implied to some in scientific programs? Or is it related to the diffusion of medical responsibility among specialists so that the living and breathing patient is somewhat submerged in waves of lab data and poorly explained therapies? Whatever the causes, the phenomenon now costs the patient or the carrier a dollar per hospital day and encourages some doctors to practice defensive medicine: the ordering of procedures not medically indicated but requested in anticipation of litigation, thus adding more to the bill. Has the physician come to be a national resource to be exploited because a lawyer may accept a case on a contingency basis so that defensive medicine, like defensive driving, must be practiced to avoid injury? What are the alternatives to malpractice suits? Compulsory arbitration? No-fault insurance? Screening panel composed of judge, lawyer, doctor? A federal program subscribed to by both physician and patient? These are some of the questions facing us nationally.

As a result of these skyrocketing malpractice insurance costs, physicians beginning practice will probably avoid states with high rates, particularly when cost of a year's coverage may exceed anticipated income, and others will leave for more placid states. Despite low rates, doctors may not be tempted to practice in this state if uproar is constant and insurance uncertain. HEW has listed 33 counties in North Carolina as short of physicians and other health professionals, a lack reflected by efforts to establish a fourth medical school in the state, appreciated by the General Assembly when it underwrote the Area Health Education Center (AHEC) Program in an effort to improve medical care and encourage innovation in its delivery and confirmed statistically by infant morbidity and mortality data.

In all medical eras, doctors have been human and made errors of commission and omission and most have learned thereby. Since the introduction of adequate anesthesia in 1846 and 1847, the opportunities to help and heal have become almost infinite, but with the opportunities have come more demands, more risks, more potent drugs, more extensive and



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dalities are used. The services consist of individual, couple, group and family psychotherapies; sexual and marriage counseling; pastoral counseling; vocational guidance and rehabilitation; alcohol and drug counseling; psychological testing, chemotherapy, electrotherapy and other somatic therapy services.



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Towards Wholeness

expensive surgery so that it is no longer permissible to attribute mishaps to "God's will." Patients have legitimate questions which we as physicians must try to answer. Patients have rights which must be

protected. Somewhere in this maze of contradictions there has to be a road of reason which will protect both patient and physician and help restore lost confidences.

Correspondence

Extracorporeal Membrane Oxygenator Project (ECMO)

To the Editor:

The University of North Carolina and the North Carolina Memorial Hospital, Chapel Hill, is one of nine medical centers participating in a National Institutes of Health sponsored collaborative program designed to determine criteria for patient selection and to evaluate the usefulness of extracorporeal membrane oxygenation (ECMO).

Despite treatment of patients with acute respiratory insufficiency following sepsis, aspiration, fat emboli, pulmonary emboli, trauma and/or major surgery, they may fail to respond to conventional therapy with continuous positive pressure ventilation and diuretics. Prolonged (5-14 days) extracorporeal membrane oxygenation (ECMO) may sustain life so that the primary pulmonary disease can be controlled, but there are no controlled data to show improved survival with ECMO when contrasted with conventional treatment, perhaps because guidelines for selection of appropriate patients for ECMO are unclear.

For consideration, patients should: (a) have an arterial pO_2 of 50 mmHg or less at an FIO_2 no less than 60 percent and with no less than 5 cm H_2O positive end expiratory pressure, (b) have these conditions present for 48 hours, and (c) be between the ages of 12 and 65. Exceptions include patients who

are deteriorating too rapidly to live 48 hours, and exclude patients with other terminal diseases, e.g., malignancy.

If a patient is eligible, the study is explained in detail to him and/or his family. The patient is then randomly assigned to either ECMO or conventional therapy. If either mode of therapy subsequently appears to be deleterious to the patient, he is removed from the study and conventional therapy employed. I recognize that there may be reluctance to refer patients unless ECMO can be guaranteed; the importance of randomization in placing ECMO in its proper perspective for therapy of respiratory insufficiency is apparent. Therefore, your assistance is requested in referring patients to us.

The cost of health care under our study is decreased since physician's fees and some laboratory costs are covered by our study program. If necessary, the ECMO physician will assist in arranging air transportation.

Physicians are urged to call the ECMO telephone number (919-966-4131) and request a physician to discuss any possible candidates. Additional questions may be directed to me in care of the Department of Surgery, UNC School of Medicine, Division of Health Affairs, Chapel Hill, North Carolina 27514 (telephone: 919-966-4507).

H. J. PROCTOR, M.D., Project Director

Committees and Organizations

Committee on Professional Insurance

Introduction

The Committee on Professional Insurance, in response to the request filed by The St. Paul Fire and Marine Insurance Company with the North Carolina Commissioner of Insurance, Mr. John Ingram, for a rate increase of 82.3 percent in professional liability insurance rates, twice recommended unanimously that the North Carolina Medical Society support this request. The Executive Council at its September 29, 1974 session concurred likewise unanimously and Dr. Frank R. Reynolds, president of the Society, reported this stand before the Commissioner December 11, 1974. Members of the Society have already been apprised by Mr. Ingram of his views and his ruling. The position of The St. Paul Fire and Marine Insurance Company, which was presented to the Executive Council in September by Mr. Donald L. Clifford, vice-president, General Liability Department, is offered below so that members of the Society can better appreciate the judgment of the Executive Council.

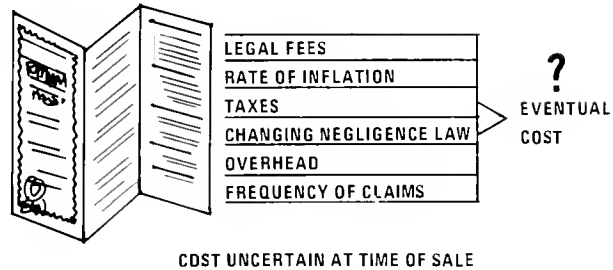
Statement of St. Paul Fire and Marine Insurance Company

The effects of increased malpractice claims, arising from many circumstances, vary from state to state. Inflation has generally increased claims payments and sharply hiked legal defense and other costs. Physicians throughout the country have felt the effect of the malpractice crisis. At the end of 1973, one out of every 11 physicians The St. Paul insured had a claim pending against him.

The St. Paul insured approximately 2,500 physicians in 1969 in North Carolina. At the end of 1969, 67 claims were pending against these physicians; one claim was pending for every 37 insured physicians. By the end of 1973, the company had insured 3,400 physicians; with 119 claims outstanding, the frequency of claims filed had risen to one in 28. At the end of June 1974, there were 163 claims outstanding; approximately one in every 20 physicians was involved with claims.

Pricing medical malpractice insurance is not a simple process (Figure). The final cost of insurance is not known until long after the product or services have been priced and sold. The only way to predict the cost of future claims is to study past claims, legal expense and other losses incurred by the

PRICING AN INSURANCE POLICY



Figure

insurer, administrative expense and, for medical liability coverages, the "long tail" (Table 1) which refers to the time elapsing from a year's business until all claims arising in that year have emerged. The company insures a physician in 1974 for any malpractice alleged to have occurred in 1974. The long tail is shown in the lapse of four or five years before the majority of injuries occurring in 1974 will be reported as claims and settled, and in the ten or more years before *all* 1974 injuries will be reported in claims. Generally, the malpractice insurance policy is an "occurrence" contract. It pays for claims and defending the insured physician against injuries alleged to have occurred during the 12-month period the policy was in force.

Thus, the nature of liability insured makes it extremely difficult to determine what happened, when it happened, how it happened, to whom and what damages resulted. To allocate funds to cover present injuries payable in the future, and to establish rates to cover claims reported in the future, an insurance company must anticipate losses. Therefore, two kinds of "reserves" — money put aside to pay for claims incurred but not settled — have been established for medical malpractice: (1) the "case reserve" based on the estimated validity of the claim and the anticipated financial settlement, and (2) the "incurred but not reported reserve" (IBNR) — a mass reserve for those injuries that the company knows are occurring and which will lead to later claims. These reserves assure that money will be on hand to cover these expected obligations.

Unknown claims must also be taken into account in establishing insurance rates. Insurance rate increases do not recover past losses. The rates established are intended to provide adequate coverage for

Table 1
The Long Tail—Development of 1969 Injuries Into Reported Claims
(Countrywide)

Year Reported	Claims (from 1969 Injuries) Reported	% of Total (1,463)	Claims Paid Each Year (Cumulative)	Claims Closed—No. Negligence Found (Cumulative)	Claims Outstanding at End of Each Year	% of Total (1,463)
1969	488	33	64	0	424	29
1970	438	30	153	223	550	38
1971	343	24	244	378	647	44
1972	147	10	338	509	569	39
1973	47	3	439	642	382	26
	1,463	100				
	† Total Claims Reported as of 12/31/73 from Injuries Occurring in 1969		† Total Claims Paid as of 12/31/73 for Injuries Occurring in 1969	† Total Claims Investigated and No Negligence Found or Otherwise Proven	† Total Claims Outstanding at 12/31/73 for Injuries Occurring in 1969	† % of Total Claims Reported (For 1969 Injuries) Outstanding as of 12/31/73

the next 12 months. Because of the long tail, the rates charged this year must bring in enough money to pay for claims and associated expenses resulting from injuries occurring this year and reported in the future. The rates charged in 1974 are the insurance company's only opportunity to collect enough money to cover the perpetual risk it takes on 1974 business.

For example (Tables 1 and 2), in 1969, 488 claims from 1969 injuries were reported to The St. Paul, and in 1970, 438 claims from 1969 injuries were reported. By the end of 1973, 1,463 claims had been reported. By the end of 1973, 439 of these claims had been paid. Another 642 had been investigated without demonstration of negligence in court by the plaintiff, and 382 claims from 1969 injuries were still pending. By December 31, 1969, the company paid only \$100,833 on 1969 injuries and had outstanding but unsettled case reserves of \$1,377,398, representing claims reported but unsettled in 1969. At the end of 1969, those 1969 injuries which were not reported to the company as claims until 1970-1973 had an undeveloped cost of \$8,143,573. Determined as of December 31, 1973, losses thus totaled \$9,621,804, an unknowable amount in 1969. The company did know the money it had paid and its reserve in 1969 were only a fraction of the losses it would

suffer. By December 31, 1973, the company had paid \$4,441,945 for 1969 injuries and had case reserves of \$5,179,859 covering claims reported but not settled.

These were nationwide figures. North Carolina experience is similar. Total incurred claims cost for 1969, claims now known and claims to be reported and settled, are estimated at \$1,987,511. This means that for every \$1.00 of premium earned in North Carolina from Physicians and Surgeons Professional Liability Insurance, the company expects to pay \$1.21 in claims and claims expense.

Whether or not the company has helped its policyholders understand its approach and its problems in establishing fair rates, it recognizes that physicians do not like the magnitude and frequency of these rate increases. The company does not like them either. It would much prefer that the claims situation stabilize. Its ability to keep its rates adequate in the face of inflation, changing law and the evolving public attitude is not impressive to its management or its shareholders. The company realizes that rate increases cannot be the only answer to the problem. Last year, The St. Paul originated a Professional Liability Risk Management Department to find ways to reduce the frequency and severity of claims and the cost of defense. The Professional Liability Risk Management Department has already developed a claims analysis system—a first in the insurance industry—which provides a detailed report of each claim by rating classification, specialty, allegation, county, date of loss and date reported, and helps the company determine trends as to the cause of malpractice claims. These and other statistical data are available to medical associations for their use in loss prevention. The department has also been investigating less costly and quicker claim settlement practices. Arbitration of medical malpractice claims is generating much interest and activity throughout the country. Finally, the communications program has been ex-

Table 2
Development of Claims on 1969 Injuries
Into Paid and Reserved Losses
(Countrywide)

Reported Year	Cumulative Paid	Outstanding Case Reserves	Undeveloped Cost (As known 12/31/73)	Total Incurred Loss (As known 12/31/73)
1969	\$ 100,833	\$1,377,398	\$8,143,573	\$9,621,804
1970	385,995	4,090,647	5,145,162	9,621,804
1971	1,594,728	6,046,980	1,980,096	9,621,804
1972	3,012,172	5,849,088	760,544	9,621,804
1973	4,441,945	5,179,859	—	9,621,804

panded to include the bimonthly publication "Malpractice Digest" for insured physicians and hospitals.

It is important for physicians to examine the situation in their own states and to determine what can

be done to prevent the erosion of customary legal defenses. In some instances, remedial legislation may be necessary to preserve and protect the nature of medical practice.

Bulletin Board

NEW MEMBERS of the State Society

Callejo, Vicente Esmele, Jr., MD (P), Cherry Hospital, Goldsboro 27530
Denuna, Vicente Bogador, MD (GS), 229 Westwood Chateau, Marion, N. C.
Ehrlichman, Gloria Stomayor, MD (PD), Beaman St., Clinton 28328
Ford, Robert Virgil, Jr., MD (PD), 1720 Grace Street, Winston-Salem 27103
Kouri, Edward William, MD (R), Charlotte Mem. Hospital, Charlotte 28201
Kupper, Ronald Milton, MD (U) Ste. H, 2400 Wayne Mem. Drive, Goldsboro 27530
Lanning, Charles Fredrick, MD (AN), Box 3094, Duke Medical Center, Durham 27710
Leininger, John Thomas, MD (U), Route 3, Box 405, Lumberton 28358
Martin, Dennis Lee, MD (N), 100 Victoria Road, Asheville 28801
McDevitt, Noel Bruce, MD (RENEWAL), UNC, Dept. of Surgery, Chapel Hill 27514
McEntire, Jerrill Lee, MD (GP), Drawer 789, Old Fort 28762
Mitchell, Stephen Ray (STUDENT), Route 3, 99 Briar Patch Road, Chapel Hill 27514
Nelsen, Margaret Ann, MD (GS), UNC, Dept. of Surgery, Chapel Hill 27514
Osborne, Raymond L., MD, Duke Medical Center, Durham 27710
Parker, William Paxton, Jr., MD, 1601 Doctors Circle, Wilmington 28401
Pollak, Michael Joseph, MD (OBG), 3020 Maplewood Ave., Winston-Salem 27103
Powell, James Blackmon, II, MD (OTO), 131 McDowell St., Asheville 28801

WHAT? WHEN? WHERE? In Continuing Education

February 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ

from the place and group or institution listed under "For information."

Programs in North Carolina

February 17-18

Regional Diabetes Teaching Nurse Workshop
Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

February 18-19

Medical Audit Team Seminars

Place: Royal Villa, Greensboro

Sponsors: N. C. Medical Records Association; N. C. Hospital Association; N. C. Medical Society

Fee: \$125

Credit: AAFP and AMA credit applied for

For Information: Mrs. Peggy Russell, RRA, Medical Records Department, Lexington Memorial Hospital, Lexington 27292

February 19

Paraneoplastic Syndromes—the Wingate Johnson Memorial Lecture

Place: Babcock Auditorium Time: 11:00-12:00 a.m.

Speaker: Prof. A. McGehee Harvey, M.D., Johns Hopkins Hospital, Baltimore, Maryland

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 21-23

Regional Duke Medical Alumni Reunion

Place: Disney World, Orlando, Florida

For Information: Office of Continuing Medical Education, Box 2991, Duke University Medical Center, Durham 27710

February 22

Learning Disabilities Seminar: A Course for Physicians and Their Wives

Place: Babcock Auditorium

Sponsors: Auxiliary to the North Carolina Medical Society and the Forsyth-Stokes Medical Auxiliary

Fee: \$5

Credit: 3 hours

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 28-March 2

Regional Duke Medical Alumni Reunion

Place: Las Vegas, Nevada

For Information: Office of Continuing Medical Education, Box 2991, Duke University Medical Center, Durham 27710

March 3-4

Nutrition in Mothers, Infants, and Pre-School Children

Place: Carolina Inn, Chapel Hill

For Information: Dr. John J. B. Anderson, Department of

Nutrition, School of Public Health, UNC, Chapel Hill 27514

March 12 & May 7
(two different workshops)

Toward More Effective Diabetic Teaching

Practical approaches to diabetic care, including some newer developments and less well-known aspects.

Place: March 12—Reidsville; May 7—Raleigh

Fee: \$20

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 16-18

Neurosciences Seminar

Sponsors: Department of Psychiatry and the Veterans Administration Hospital, Duke University Medical Center

For Information: John L. Sullivan, M.D., Assistant Professor of Psychiatry, Veterans Administration Hospital, Durham 27705

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract

Place: Governors Inn, Research Triangle Park (between Durham and Raleigh, near the airport.)

Program: Designed for radiologists, but open to other physicians in training or practice. Emphasis on personalized, tutorial type teaching, with ample opportunity for discussion. Two 1 hour 20 minute tutorial sessions each morning, and one in the afternoon; 12 registrants will join one faculty member in a separate quiet room with viewboxes for organized film reading-discussions and case presentations. Each registrant will have a total of 14 different tutorial sessions. One hour "Panel" presentation-discussion each afternoon. Guest faculty include: Drs. Charles A. Bream, Harley C. Carlson, Joseph T. Ferrucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S. Wolf, and, from Kings College Hospital, London, England, Dr. John Laws, Chairman, Department of Radiology.

Fee: \$300; enrollment limited

Credit: 28 hours AMA "Category One" accreditation

For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 19-20

4th Annual Cancer Registry Symposium—In addition to liaison physicians, cancer registrars and medical records librarians of the participating hospitals, others working in the field of cancer are invited to attend.

Place: Crabtree Howard Johnson, Raleigh

Sponsors: North Carolina Central Cancer Registry; North Carolina Regional Medical Program; North Carolina Division of the American Cancer Society

For Information: Mr. Cory Menees, Cancer Program Manager, Division of Health Services, Chronic Disease Branch, P. O. Box 2091, Raleigh 27602

March 19-22

North Carolina League for Nursing Annual Meeting

Place: Sir Walter Hotel, Raleigh

Sponsors: NCLN and the National League for Nursing

For Information: Ms. Marie Robeson, Director of Nursing, Watts Hospital, Durham 27706

March 25-26

Problem-Oriented Medical Record System

Through a video-tape simulated case presentation, participants will be involved in learning to use the POMR through actual involvement.

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 25-27

Cardiac Arrhythmia Course

Place: Room 1367

Fee: \$85

For Information: Galen Wagner, M.D., P. O. Box 3327, Duke University Medical Center, Durham 27710

March 27-28

The Nursing Audit

Designed to assist nursing administrative personnel in evaluating the quality of patient care through the use of a systematic auditing technique.

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 28

9th Malignant Disease Symposium—Childhood Malignancy
Place: Berryhill Hall, UNC School of Medicine, Chapel Hill

Sponsors: Department of Pediatrics and the Office of Continuing Education

Fee: \$35

Credit: 5 hours; AAFP approved

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 28-29

Eleventh Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning

The program is designed for practitioners and residents in Obstetrics and Gynecology. There will be three basic themes: "Fertility: Enhancement and Inhibition"; "Advances in Perinatology"; and "Human Sexuality: Problems that Confront the Gynecologist."

Fee: \$60; no charge for residents or students

For Information: Charles B. Hammond, M.D., P. O. Box 3143, Duke University Medical Center, Durham 27710

April 4-5

Pediatric Postgraduate Course

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 7-11

Practical Approaches to Diabetic Care

Program especially suitable for nurses caring for large numbers of diabetic patients. Emphasis on teaching needs of diabetic patients and how to meet them.

Fee: \$125

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 10

Rheumatoid Arthritis—10th Annual Wilson Memorial Hospital Postgraduate Symposium

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

Speakers will include Dr. John Davis, University of Virginia Medical Center, Dr. Donald McCollum, Duke University Medical Center, Dr. Edwin Martinat, Bowman Gray School of Medicine and Dr. Carwile LeRoy, Columbia-Presbyterian Medical Center

For Information: A. Tyson Jennette, M.D., Wilson Memorial Hospital, 1705 South Tarboro Street, Wilson 27893

April 11

North Carolina Diabetes Association Eighth Annual Scientific Session

The program will include a scientific session for physicians and a separate and concurrent session for laymen

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 12-13

1st Annual Colloquium on Practical Rheumatology

Place: Carolina Inn, Chapel Hill

Sponsors: Division of Rheumatology and Clinical Immunology, Department of Medicine with the Office of Continuing Education, UNC School of Medicine

Fee: \$50

Credit: AAFP credit applied for

For Information: Oscar L. Sapp, III, M.D., Associate Dean

OFFICIAL CALL HOUSE OF DELEGATES

pursuant to the Bylaws, Chapter IV, Section 1:

HOUSE OF DELEGATES Meetings scheduled

**Notice to: Delegates, Alternate Delegates, Officials
of the North Carolina Medical Society, and Presidents
and Secretaries of county medical societies.**

Sessions of the HOUSE OF DELEGATES will convene in
the Cardinal Ballroom, The Carolina, Pinehurst, North
Carolina, at the following times:

Thursday, May 1, 1975—2:00 p.m.—Opening Session

Saturday, May 3, 1975—2:00 p.m.—Second Session

A member of the CREDENTIALS COMMITTEE will be present at
the Desk in the Registration Office, Thursday, May 1, 1975, from
8:30 a.m. to 12:30 p.m. to certify Delegates. Delegates are urged
to bring their Credential Cards for presentation at the Registration
Office. Delegate Badges must be worn to be seated in the HOUSE
OF DELEGATES.

REFERENCE COMMITTEE HEARINGS

Reference Committee hearings are scheduled for Friday, May 2, 1975, at 2:00 p.m.

FRANK R. REYNOLDS, M.D., President
CHALMERS R. CARR, M.D., Speaker
E. HARVEY ESTES, JR., M.D., Secretary
WILLIAM N. HILLIARD, Executive Director

for Continuing Education, UNC School of Medicine,
Chapel Hill 27514

April 21-22

Primary Nursing

Participants will explore the use of the primary system and its relationship to other systems, and identify its influence on the nursing process, patient care and staffing.

Fee: \$50

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 21-24

Recent Advances in Allergy

Place: The Homestead, Hot Springs, Virginia

Seminar sessions will be held from 8:00 a.m. to 10:00 a.m. on each of these four days.

For Information: Claude A. Frazier, M.D., Building 4, Doctors Park, Asheville 28801

April 23-25

Maternal Health and Family Planning

Designed to assist nurses to conduct classes for parents in prepared childbirth.

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 24, 1975

Craven County Hospital Annual Medical Symposium

Place: New Bern

Program: "Infectious Disease"

Sponsors: Craven County Hospital

For Information: Zack J. Waters, Jr., M.D., Director of Medical Education, 800 Hospital Drive, Medical Arts Center, New Bern, N. C. 28560

May 1-4

121st Annual Session of the North Carolina Medical Society; General Session on Scientific Subjects and Specialty Section Meetings

Place: Pinehurst Hotel and Country Club

For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

May 7-14

Medical Seminar Cruise

Place: Sailing from Charleston, South Carolina, and calling on the ports of San Juan and St. Thomas

Sponsors: North Carolina Medical Society; South Carolina Medical Society; Division of Continuing Education of the Medical University of South Carolina

Fee: \$100 deposit to insure reservation; cabin rates from \$360 to \$640

Credit: 22 CE units

For Information: Medical Seminar Cruise, Southern International Travel Corporation, P. O. Box 19372, Raleigh 27609

May 12-13

Family Planning Seminar

Place: Carolina Inn, Chapel Hill

Sponsors: Department of Obstetrics and Gynecology; School of Nursing; Office of Continuing Education

Fee: \$50

Credit: 11 hours; AAFP approved

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 13-14

Breath of Spring, '75—Respiratory Care Symposium

Place: Babcock Auditorium

Sponsors: Division of Continuing Education, Bowman Gray School of Medicine; Northwestern Lung Association

Fee: \$25

Credit: 12 hours credit; AAFP applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 28-29

Endoscopy Workshop

Place: Berryhill Hall, UNC School of Medicine, Chapel Hill

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy. Lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE

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San Juan, Puerto Rico 00936

Address medical inquiries to:

G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

454 R

Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine

Fee: \$75

For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop

Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
Sponsors: Divisions of Continuing Education, Bowman Gray, Duke and UNC Schools of Medicine, and the Medical University of South Carolina

Fee: \$100

Credit: 20 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the Veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

- | | | |
|----------|-----|--|
| February | 19— | 1 p.m., "Blood Gases" |
| | | 2 p.m., "Neurological Diagnostics" |
| February | 26— | 1 p.m., "Oral Cancer Detection & Treatment" |
| | | 2 p.m., "Antibiotics: Uses and Abuses" |
| March | 5— | 1 p.m., "Psychotherapeutic Drugs" |
| | | 2 p.m., "Fiberoptic Endoscopy and Sigmoidoscopy (Cancer of the Colon)" |
| March | 12— | 1 p.m., "Schizophrenia" |
| | | 2 p.m., "Cirrhosis and Ascites" |
| March | 19— | 1 p.m., "Heart Sounds" |
| | | 2 p.m., "Respiratory Intensive Care" |
| March | 26— | 1 p.m., "Cancer of the Colon" |
| | | 2 p.m., "Care of the Cancer Patient" |

As this schedule has been subject to some change in the past, it might be advisable to check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)

Oteen—Stewart Scott, M.D. or Mary Ellen Lutz, R.N. (298-7911)

Salisbury—Mr. Dante Spagnolo (636-2351)

Programs In Contiguous States

February 16 and 18

Cancer of the Breast

Place: Hyatt Regency Atlanta, Tudor Suite, Atlanta, Georgia
Sponsors: The American Cancer Society, Inc.; American College of Surgeons

Fee: \$100 for members of the Southeastern Surgical Congress; non-members \$125

Program: The program on Sunday, February 16 will be: a.m.—"Appraisal of Initial Lesion"; p.m.—"Management of Primary Site." On Tuesday, February 18 the meeting is scheduled from 2:00 p.m. to 4:00 p.m.; the topic is "Management of Patient with Residual Cancer"

For Information: A. Hamblin Letton, M.D., Sec.-Dir., Southeastern Surgical Congress, 315 Boulevard, N.E., Suite 500, Atlanta, Georgia 30312

February 17-20

Southeastern Surgical Congress, 43rd Annual Assembly, for Doctors & Nurses

Place: Hyatt Regency Atlanta Hotel, Atlanta, Georgia

For Information: A. Hamblin Letton, M.D., Secretary-Treasurer, The Southeastern Surgical Congress, 315 Boulevard N.E., Atlanta, Georgia 30312

February 24-28

Nuclear Medicine

Place: Conference Center, Williamsburg, Virginia

Sponsor: Department of Radiology, Medical College of Virginia

Fee: \$175; residents \$75; separate daily attendance \$50

Credit: 19½ hours AMA; certificate of attendance awarded

For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

February 28-March 2

Annual Meeting Virginia Chapter American Academy of Pediatrics

Place: Colonial Williamsburg, Virginia

Fee: \$10

For Information: James H. Stallings, Jr., M.D., Secretary-Treasurer, Virginia Chapter American Academy of Pediatrics, 6503 N. 29th Street, Arlington, Virginia 22213

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

May 12-15

Cardiology for the Internist

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: American College of Cardiology; Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine, Atlanta, in cooperation with Georgia Heart Association

For Information: Miss Mary Anne McNerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Rehabilitation of Stroke Patients

A series of workshops on rehabilitation of stroke patients will be conducted as a special project of the South Carolina Heart Association. The overall goal of the project, entitled "Regionalization of Specialized Nursing Home Services," is to upgrade the care of geriatric patients through the latest methodology in stroke patient care. Each workshop will consist of a two-day training session and a one-day follow-up session for review and evaluation. Dates and locations of the remaining workshop sessions are as follows:

February 18-19 & April 3—Columbia, S. C.

February 25-26 & April 9—Florence, S. C.

March 11-12 & May 1—Myrtle Beach, S. C.

March 18-19 & May 6—Spartanburg, S. C.

For Information: Mrs. Dolores J. Wilkie, P. O. Box 5937, Columbia, S. C. 29250

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

COMMUNITY HEALTH

With varied life styles and increased fluidity and mobility of our society, individual health problems quickly become community concerns, as disease and mental stresses take their toll. The increased frequency of contact between people accelerates the growth and spread of all health and safety problems. A single unimmunized person can quickly cause an epidemic; an uncorrected safety hazard can claim the life or productivity of vital members of a com-

munity, and rob all of needed services; unchecked pollution can shorten the life span and significantly lower the quality of life for all. Concern for other people and the community, therefore, quickly overlaps with self-concern and concern for our own immediate families.

Our society has changed and has been assigned new roles. We, too, as a medical auxiliary, must change our role to fill the new community needs. We have traditionally been instrumental in carrying out mass screening and immunization campaigns and effecting stop-gap measures in an emergency. Now the time has come to create long-range improvements in community health. As members of the medical community, we are familiar with available health resources and are in a position to help correct health and safety deficiencies through education and service.

There are some basic steps and principles which apply to virtually every project an auxiliary might undertake in community health: (1) Survey the community to learn specific needs, resources available and programs or efforts now in effect, (2) establish priorities for meeting the most pressing community needs and use these as a basis for establishing a long-range plan of action, and (3) plan and carry out programs in order of established priorities. Each step is important, but creating public awareness is especially important; it is in this process that much educational activity can be included.

ECOLOGY

One of the most pressing problems of our times is that of the environment. No matter how large or how small a medical auxiliary is, ecology is an area in which we can have 100 percent participation. Many of you already have participated on an individual basis and have felt a sense of dedication in saving our earth. To most of us, the "environment" represents the life-sustaining elements of air and water. We must continue our efforts to prevent its pollution. Additionally, the shortage of raw materials and natural resources is *absolutely* real. Our efforts in recycling *must* continue and increase.

BLOOD DONORS

Critical shortages of blood have existed recently. Blood procurement programs are therefore vital. Every day more than 13,000 units of blood are transfused in the United States — nearly 6,000,000 units per year. Many organizations throughout North Carolina assist in blood procurement programs. Surely, every auxiliary should have a part in the community blood programs, whether it be Red Cross or the hospital blood bank efforts.

AGING AND HOME BOUND

Most important here are INTEREST, PATIENCE and PERSONAL VISITS. The Volunteer Visitor Program provides Meals on Wheels for the aged and home bound, a service that has been initiated

by many of the churches and staffed by volunteers from the community.

We must be aware of the central homes for the aging (church and private) and their needs, as well as the needs of particular persons in your locale. On holidays we can make a special effort to visit, and take our children with us. Nothing cheers up an elderly person more than young children and teenagers. Perhaps, too, small inexpensive gifts or home-made goodies could be collected by your organization.

Loneliness is the chief problem of the aged. Another is the problem of adjustment to retirement—especially for men. A telephone reassurance program (TELECARE) is vital. And patience, at times, is required, for the aged may be confused or sensitive. A friendly, patient listening ear can mean much.

SAFETY

In the large cities and the small, the streets and highways remain high on the list of KILLERS. Freedom from fear is a fundamental right of every human being, yet accidents and assaults are occurring sometimes hourly. The National Safety Council has announced a national call for a women's crusade for SAFETY ON THE STREETS (S.O.S.).

The National Auxiliary Chairman of Community Health suggests, "Much has been said these days about each American's right to good health and adequate medical services. Each American also has a right to help himself achieve good health. Perhaps, through our efforts in Community Health, we can help him to help himself to achieve this right and to improve the quality of life for us all."

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Carl Gottschalk, School of Medicine, UNC-Chapel Hill, has been chosen president-elect of the American Society of Nephrology. He will assume the duties of president of the Society at its annual meeting in November 1975. Dr. Gottschalk, Kenan Professor of Medicine and Physiology at UNC, is a career investigator for the American Heart Association.

* * *

Dr. Kenneth Sugioka, chairman of the Department of Anesthesiology, UNC School of Medicine, has been named president-elect of the Society of Academic Anesthesia Chairmen. The organization meets annually to establish guidelines for departmental activities—teaching, research, patient care and the role of anesthesiology in an academic setting. Membership is limited to full-time academic chairmen of depart-

ments of anesthesiology in the 100 medical schools in the United States.

* * *

The School of Medicine has gained three new faculty members:

Peter V. Scott, associate professor, Department of Anesthesiology, spent last year as a consultant anesthesiologist to the University Hospital of Wales, Cardiff, England. He received his medical training at the University College Hospital Medical School, University of London.

Kenneth Dee Carey, assistant professor, Department of Pathology, and veterinary pathologist, Division of Laboratory Animal Medicine, holds the B.S. and D.V.M. from the University of Illinois. Since 1970 he has been a research associate in veterinary pathology at the University of Missouri where he is completing his Ph.D.

George T. Wolff, assistant professor, Department of Family Medicine, will be director of the Family Practice Residency Training Program at the UNC/Cone Hospital teaching program. A native of Greensboro, he received his B.S. at UNC-Chapel Hill and his M.D. at Jefferson Medical College.

* * *

In the Department of Family Medicine, School of Medicine, Robert D. Stone has been promoted to assistant professor.

Emily S. Barrow, associate professor, Department of Pathology, School of Medicine, will take a year's leave beginning April 1, 1975, to pursue a research and study program on the development of antibodies to Factor VIII in hemophiliacs at the French Red Cross Center for Hemophiliac Children in Yvelines, France.

* * *

In the UNC School of Medicine the following have resigned:

John M. Danielson, professor, Department of Hospital Administration, and director, North Carolina Memorial Hospital, resigned Oct. 25, 1974, to accept a position in Connecticut as director of a nine-hospital consortium which includes the Hartford Hospital, University of Connecticut Teaching Hospital and other major hospitals in the area.

Lewis C. Becker, assistant professor, Department of Medicine, resigned Oct. 31, 1974, to accept a position at Johns Hopkins School of Medicine.

Peter W. Munt, assistant professor, Department of Medicine, resigned Oct. 31, 1974, to accept a position at Queen's University, Kingston, Ontario, Canada.

Stanford A. Roman, assistant professor, Department of Medicine, resigned Aug. 31, 1974, to accept a position at Boston City Hospital.

Robert J. Sullivan, Jr., assistant professor, Depart-

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GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

ment of Medicine, resigned Aug. 31, 1974, to accept a position at Duke Medical Center.

* * *

Dr. Arthur H. Keeney, former chief of Wills Eye Hospital in Philadelphia, now professor of ophthalmology and dean of the Medical School of the University of Louisville, gave the 13th McPherson Lecture at the UNC School of Medicine on Dec. 14.

* * *

Dr. Lucy H. Conant, dean of the UNC School of Nursing, Chapel Hill, since 1968, will resign her position effective June 30, 1975. She will return to her home in the Berkshire hills of Massachusetts where she plans to stay involved in nursing and health care on a part-time basis. In her letter of resignation Dr. Conant explained, "There are other items on my personal agenda for living. When I came to Chapel Hill nearly seven years ago, I owned some land in the Berkshire hills in Massachusetts. I have been a farmer at heart all my life and now my plan is to see what I can do with those 150 acres."

* * *

The University of North Carolina, Chapel Hill, has been awarded \$2.5 million to continue for the next two years the coordination of an international study probing the role of high blood fats in coronary heart disease. The new HEW funding is part of a seven-year, 14-university project started in 1971. UNC has received \$4 million to date to support its role in the Lipid Research Clinics Program under the research program of the National Heart and Lung Institute.

UNC's role has been to establish and operate a Central Patient Registry and Coordinating Center for the international study. The UNC Center has assisted in planning and monitoring the research centers across the United States, Canada and the USSR and in the collection, storage and interpretation of data.

Dr. James E. Grizzle, chairman of the UNC School of Public Health's Department of Biostatistics, is project director.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Robert Burgess Jennings has been appointed chairman of the Department of Pathology, effective next June 1.

Jennings currently is chairman of the Pathology Department at the Northwestern University Medical School in Chicago, a post he has held since 1969.

He will succeed Dr. Thomas D. Kinney, chairman of pathology at Duke since 1960, who is retiring

Rondomycin[®]

(methacycline HCl)

CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the oropharyngeal region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanelles, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin[®] (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin[®] (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb./day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin[®] (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/75



WALLACE LABORATORIES
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from administrative responsibilities to devote full time to teaching and research.

Jennings, 48, has spent most of his professional career at Northwestern, where he rose from instructor to full professor in ten years. He received bachelor's degrees in chemistry and medicine and a master's in pathology at Northwestern and earned his M.D. degree there in 1950. His internship and pathology residency were served at Passavant Memorial Hospital in Chicago.

Jennings' central area of research has been cell injury. He is known especially for his studies of the mechanism of cell death following diminished blood supply to the heart as in myocardial ischemic injury and myocardial infarction. He was one of the earliest researchers to concentrate in that area and to apply electron microscopy and biochemical techniques. He also has done work in the natural history of kidney diseases using renal biopsy techniques.

* * *

Dr. Donald Silver, professor of surgery, is the new chairman of the Department of Surgery at the University of Missouri-Columbia School of Medicine and Medical Center, effective Feb. 1. He also will have the title of W. Alton Jones Distinguished Professor of Surgery.

A native of New York City, Silver received both his undergraduate and medical degrees at Duke, finishing medical school in 1955. Following house staff duty at Duke, he was appointed to the faculty in 1963. He was named full professor in 1972.

* * *

Russell James Kilpatrick, a medical school junior, has received a \$1,000 check from the International College of Surgeons to help defray costs of a summer of travel and study in South Africa. The check was presented on behalf of the College by Dr. Howard E. Strawcutter of Lumberton.

* * *

Dr. Redford B. Williams, Jr., assistant professor of medicine and psychiatry here, has received a Research Scientist Development Award from the National Institute of Mental Health.

The award, which amounts to approximately \$170,000 over the next five years, will enable Williams to conduct research into the relations between stress, hypertension and heart disease while at the same time receiving additional training in medical areas which may have a bearing on his studies.

Williams is a 1963 graduate of Harvard and a 1967 graduate of Yale University School of Medicine. He served his internship and residency in internal medicine at the Yale-New Haven Medical Center, and prior to coming to Duke in July 1972, he was a clinical associate in the Laboratory of Clinical Psychobiology at the National Institute of Mental Health in Bethesda, Md.

* * *

Dr. Jaime Zusman, a 29-year-old leukemia specialist, has joined the Comprehensive Cancer Center as

director of cancer chemotherapy. He also has been appointed assistant professor of pediatrics in the School of Medicine.

Zusman graduated from Utica College of Syracuse University with a B.A. degree in 1965. Four years later, he received his M.D. degree from Johns Hopkins University. He served his internship in pediatrics at the University of Chicago Hospital and his residency at the University of Minnesota Hospitals.

* * *

Dr. Leonard Goldner, chairman of the division of orthopaedic surgery, has been invited by the Armed Forces Institute of Pathology to serve on its Scientific Advisory Board of Consultants. His appointment is for a five-year period ending in October 1979.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

A Department of Medical Social Sciences and Marital Health has been established at Bowman Gray, replacing the Behavioral Sciences Center. The new department's academic status more accurately reflects the functions of the center's staff, which has been participating actively in teaching, research and clinical service programs of the medical center.

With the medical school's adoption of a curriculum that emphasizes behavioral sciences instruction throughout the four years of medical education, the center's teaching role has increased considerably during the past five years.

Dr. Clark E. Vincent, who has been director of the center, has been named chairman of the new department.

* * *

The American Professional Practice Association has established a scholarship at Bowman Gray to honor Dr. Leland E. Powers, director of the school's Division of Allied Health Programs since 1968. Dr. Powers was named professor emeritus of community medicine Jan. 1 upon his retirement from the full-time faculty.

Dr. Powers is president of the American Professional Practice Association, and was instrumental in forming the National Association of Interns and Residents, from which the APPA developed. The scholarship is to be given annually to a first-year medical student.

* * *

Francis E. Garvin of Wilkesboro has been elected chairman of the Medical Center Joint Administrative Board of Bowman Gray and North Carolina Baptist

Hospital. He succeeds the Rev. Frank R. Campbell of Statesville.

Dr. Claude A. McNeill Jr., an Elkin physician and a trustee of Wake Forest University, was re-elected vice chairman.

The joint board, consisting of representatives from the Wake Forest and Baptist Hospital trustees, was delegated last year the responsibility for overall direction of the medical center.

* * *

Dr. Eben Alexander, Jr., professor of neurosurgery has been reappointed chairman of the Section Council on Neurological Surgery of the American Medical Association.

* * *

Dr. Donald M. Hayes, professor and chairman of the Department of Community Medicine, has been named a member of the North Carolina Drug Authority Education Task Force.

* * *

Dr. Felda Hightower, professor of surgery, was elected first vice president of the Southern Surgical Association during its December meeting in Boca Raton, Fla.

* * *

Dr. Paul C. Bucy, clinical professor of neurology and neurosurgery, has been selected as the first Samuel R. Snodgrass Lecturer in Neurosurgery at the University of Texas Medical Branch in Galveston.

Dr. Bucy, a long-time friend of Dr. Snodgrass (who was on the faculty of the University of Texas Medical Branch for 35 years), will speak on the problems confronting neurological surgeons and their future.

* * *

Dr. Charles L. Spurr, professor of medicine, has been appointed a member of the Cancer Control Review Committee of the National Cancer Institute.

NEW HAMPSHIRE HISTORICAL SOCIETY

The New Hampshire Historical Society is sponsoring a project to edit the papers of Josiah Bartlett (1729-1795), with Frank C. Mevers as editor. Supported by the N.H. American Revolution Bicentennial Commission and the National Historical Publications Commission, the project will result in a comprehensive microfilm edition followed by a letterpress edition of selected documents.

Persons having knowledge of the existence of correspondence to or from Bartlett or of other papers written or signed by him are requested to contact the Historical Society at Thirty Park Street, Concord, New Hampshire 03301.

RESEARCH TRIANGLE INSTITUTE PROJECT

Research Triangle Institute is developing methods for making more reliable estimates of the incidence,

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. Usage in Pregnancy: Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

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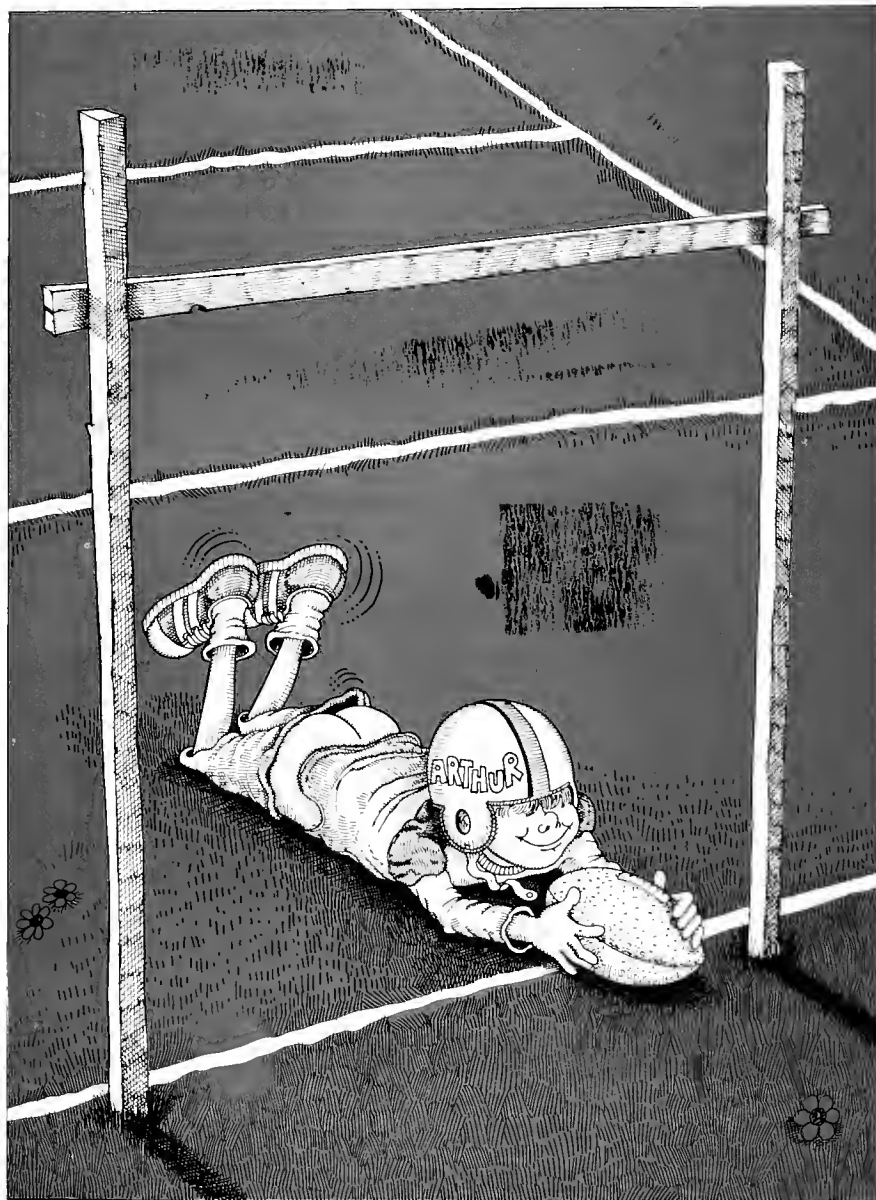
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prevalence and costs of cranio-cerebral and spinal cord injuries which may affect up to eight million Americans at any given time. The program, sponsored by the National Institute of Neurological Diseases and Stroke, will include a nationwide case-survey to gather data for analysis to derive rates and determine costs of CNS injuries; this information will be of value in planning and developing better measures for effective prevention and treatment.

A medical advisory committee is composed of Dr. Thomas W. Farmer, professor of neurologic medicine, School of Medicine, University of North Carolina at Chapel Hill; Dr. Michel A. Ibrahim, professor of epidemiology in UNC's School of Public Health; Dr. Edwin Martinat, John C. Whitaker, Regional Rehabilitation Center, Winston-Salem; Dr. Blaine S. Nashold, Jr., professor of Neurosurgery, Duke University Medical Center; Dr. Jesse F. Kraus, University of California at Davis; Dr. Judith R. Lave, Carnegie-Mellon University, Pittsburgh; Dr. Robert

McLaurin, Cincinnati General Hospital; Dr. Martin Naeman, Strong Memorial Hospital, Rochester, N. Y.; Dr. Monroe Sirken, National Center for Health Statistics, Rockville, Md.; and Dr. Dewey Ziegler, University of Kansas Medical Center.

BLOOD UTILIZATION COMMITTEE FORMED

An ad hoc Blood Utilization Committee has been formed to study the collection, distribution and utilization of blood in North Carolina. Dr. Robert Langdell, Professor of Pathology at the University of North Carolina School of Medicine, and Dr. Inez Elrod, Medical Director of the Piedmont Carolinians Red Cross Blood Center, are co-chairmen. This committee's activities are open to interested parties. The initial work of the committee will be to survey the matters mentioned in its objectives from a statistical standpoint, and in coming months those involved with blood banking will be contacted.



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Month in Washington

The 93rd Congress has concluded its two-year session that was highlighted by the historic Watergate affair. Congress held hearings but took no action on a National Health Insurance (NHI) program. However, the lawmakers approved during the last days a health planning bill anticipating NHI. Earlier, they voted for a liberalization of the Keogh plan allowing self-employed people to set aside much higher amounts for their retirement subject to tax deferral. Aid for medical education legislation foundered and will be revived this year.

The Democratic victories in the November elections, the Democratic push for legislative reforms within Congress, and the downfall of Rep. Wilbur Mills (D., Ark.) as Chairman of the House Ways and Means Committee signalled a more liberal and activist Congress in 1975.

The House Democratic Caucus voted to pack Ways and Means, which has the prime jurisdiction over NHI, with liberal Democrats and enlarge its membership to 37, compared to 25 last year. The ratio in 1975 is 25 Democrats, 12 Republicans. Rep. Al Ullman (D., Ore.) is the new chairman. For the first time, Ways and Means will be broken into subcommittees. The Subcommittee on Health is headed by Rep. Dan Rostenkowski (D., Ill.).

The Caucus stripped Committee Democrats of their long-held power to appoint all House Democrats to committee slots, a move that weakened Ways and Means.

* * *

On the final day of the session in December, the last Congress approved legislation giving health planning agencies strong new authority over hospital services and construction. The lawmakers failed to reach agreement on health manpower bills that would have required many young physicians to serve in shortage areas and dictated apportionment of specialization education at medical schools.

Both measures had stirred controversy and generated opposition among health groups. The planning bill's most disputed original provisions would have paved the way for public utility-type regulation of physicians' services as well as those of institutions. These were dropped from the final version sent to the White House.

The health manpower bill had been toned down from the one first backed by Sen. Edward Kennedy (D., Mass.) and approved by the Senate Labor and

Public Welfare Committee. A more moderate substitute was adopted on the Senate floor minus such items as relicensing of physicians. However, medical schools and medical provider organizations, including the American Medical Association, had contended the scaled-down bill was still too harsh in its effect on young physicians and medical schools. This opposition and Sen. Kennedy's decision to block action this year killed the health manpower legislation. Meantime, existing programs will continue as in the past.

The planning bill, approved by a 236-79 House vote a few weeks previously, was swiftly adopted by a House-Senate conference which ironed out differences in the bills approved by the two chambers. The compromise was adopted by the House and Senate only hours before the 93rd Congress quit.

Conceived as a preparatory measure to gear for a national health insurance program, the planning bill sets up an elaborate system of federal standards and regulations covering state and local health planning agencies and endowing them with strong power to force institutions to abide by planning decisions on services. All new hospital building and expansion would be subject to rigid controls.

The aim is to avoid waste and duplication, provide efficiency, raise quality and availability, and relieve shortage areas. The incentive for the states is federal aid. The ultimate impact of the bill will be increased control from the state and federal level on institutional health care.

Writing the regulations to carry out the program will take a long time, as will the ensuing administrative work of putting the planning scheme into operation. The bill provides for the establishment of local and state agencies for the development of comprehensive health plans under national guidelines developed by the Secretary of Health, Education and Welfare. Health systems agencies would be set up throughout the United States. The bill requires that all states enact certificate of need legislation; it expands existing review authority over existing facilities and services as well as proposed facilities. The measure authorizes federal assistance to no more than six states which have rate setting legislation or are planning such legislation in the near future. This demonstration federal assistance would be given to designated state health planning and development agencies for the regulation or establishment of rates for the pay-

ment or reimbursement of those engaged in the delivery of health services.

Under the bill, a National Council on Health Planning and Development will make recommendations on national guidelines and implementation and evaluate "the implications of new medical technology for the organization, delivery, and equitable distribution of health care services." Health services areas would be established throughout the United States.

A health systems agency for a health service area will be a nonprofit private corporation (or similar legal mechanism such as a public regional corporation) which is incorporated in the state; or a public regional planning body if it has a governing board composed of a majority of elected officials of units of general local government if the area of the jurisdiction of that unit is identical to the health service area.

State health planning and development agencies would conduct the health planning activities of the state and implement those parts of the state health plan and the plans of the health systems agencies within the state which relate to the government of the state. A state health planning and development agency shall be advised by a statewide health coordinating council.

* * *

Strict utilization review procedures for Medicare and Medicaid were ordered by the HEW Department. The final regulations tighten and standardize hospital and skilled nursing home admission and stay rules for federal program beneficiaries. They are designed to be applicable to all patients and to fit in with any future NHI program.

"Health care is an expensive and scarce resource," commented HEW Secretary Caspar Weinberger. "We must learn now to make the most efficient use of it before National Health Insurance places additional demands on the system." The regulations are expected to have a great impact on all hospital and nursing home review operations.

The HEW Department said they are compatible with and supportive of HEW's Professional Standards Review Organization (PSRO) program, and will permit an orderly transition to the operation of the PSROs. While the nationwide PSRO program is one to two years away from full scale operation, review under these new regulations can begin now in all facilities serving eligible persons. The regulations implement provisions of the Social Security Amendments law approved by Congress in 1972.

A controversial feature of the earlier proposed regulations requiring pre-admission certification drew a flood of protests—8,000 adverse comments of 8,300 responses overall—and was dropped from the final regulations. The new requirements and the major changes in the final regulations which modify conditions of participation by hospitals and skilled nursing facilities in Medicaid and Medicare programs are: (1) Hospitals will be required to undertake con-

current admission review, rather than prior approval as first proposed. Approved length of stay will be based on patients' condition and diagnosis and will be subject to extension, if medically justified. (2) Timely review of a patient's need for continued hospitalization according to criteria developed by the review committee, and retrospective review of the quality of care through medical care evaluation studies. (3) Composition of the utilization review committee has been changed to permit professional personnel employed by hospitals to be members.

In addition, under Medicaid, states will be required to establish utilization control programs which include provisions for (1) physicians' certification at admission and every 60 days thereafter of a patient's need for institutional care; (2) development and review of a plan of care for each patient; and (3) on-site inspections to determine adequacy and quality of services.

HEW describes hospital admission review rules for Medicare and Medicaid: (1) All patients admitted under Medicare or Medicaid are reviewed; (2) review within one working day of admission and final determination made within two working days; (3) review using criteria and standards developed by the utilization review committee; (4) appropriate regional norms are used, where available, to assist in assigning a date for extended stay review; and (5) selected diagnosis/problems, practitioners; or institutions which present problems are reviewed in greater depth.

For hospital stay review, all patients still in the hospital on the date assigned at admission will be reviewed. They will be reviewed prior to or on the date assigned at admission. A final determination is made within two working days of the end of the certified period. The review employs criteria and standards developed by the utilization review committee.

The purpose of required medical care evaluation studies "is to improve the quality of medical care and the efficiency of health care delivery," HEW said. The studies will be retrospective with in-depth reviews of known or suspected problem areas in medical care and should identify specific needed changes, and lead to appropriate action programs to make such changes, i.e., programs of continuing education. Each institution must have at least one study in progress at any point in time and must complete at least one study annually.

* * *

Charles Edwards, M.D., resigned as Assistant Secretary for Health at the HEW Department. He will become Senior Vice President of Becton, Dickinson and Company, manufacturer of medical and surgical equipment in Rutherford, N. J.

Dr. Edwards, 51, served five years at HEW, starting in 1969 as Commissioner of the Food and Drug Administration. Previously, he was an executive with the management consultant firm Booze, Allen, and

Hamilton, and director of the Division of Socio-economic Activities of the American Medical Association.

* * *

President Ford vetoed the \$1.8 billion health revenue sharing and health services bill which provided authorizations for Community Mental Health Centers, migrant workers, and Neighborhood Health Centers. These programs will be funded on an interim basis until Congress takes another crack this year. The Administration had opposed many provisions, and the veto was no surprise.

President Ford said the bill called for three times as much spending as the Administration wanted. It provided \$320 million for health revenue sharing programs in 1975-76. Community health centers were authorized \$258 million for the two years.

Migrant health centers would have been authorized \$105 million for grants to establish and operate in high-impact areas. Family planning services were authorized \$334 million for project and training grants and contracts. Home health services would have received \$15 million.

* * *

The Supreme Court refused to block a lower court requirement that drug manufacturers warn parents during community-wide vaccination drives that vaccine might be harmful. The American Medical Association, pediatricians and epidemiologists had warned that parents' fears could hamper inoculation campaigns. Manufacturers are required by the Federal Government to include warning pamphlets in drug shipments to pharmacists. There is no requirement to warn the patient. The Supreme Court appeal was brought by Wyeth Laboratories, manufacturer of a Sabin oral vaccine which was used during a 1970 drive to combat a polio epidemic in Hidalgo County, Tex.

* * *

The American Medical Association urged the Administration to explore with it the feasibility of legislation dealing with the malpractice liability of phy-

sicians in treating beneficiaries of federal programs. In a message delivered to HEW Secretary Caspar Weinberger by AMA President Malcolm C. Todd, M.D., and Richard Palmer, M.D., chairman of the AMA Board of Trustees, the Association declared that "what is needed is a swift system for paying deserving claims so that justice can be prompt. For both the physician accused of malpractice, who bears a severe emotional burden, and the patient who becomes an unfortunate plaintiff, justice delayed is justice denied."

The letter by Dr. Todd noted that in 1975 as much as 50 percent of the cost of health care may be provided through government-sponsored plans and programs. Dr. Todd said at present it is estimated that after all costs of the tort system are met—fees to defense and plaintiff's attorneys—and witnesses, costs of investigation, and insurance underwriting, plaintiffs actually receive a net of only \$1.00 out of every \$6.00 paid in premiums for hospital and physician's liability insurance.

He pointed out that government health care programs now contribute a major part of the cost of a system which provides claimants with only 16 cents out of every dollar paid for malpractice insurance. The remainder goes for the services of plaintiffs and defense lawyers, investigators, witnesses, insurance carriers and brokers, and miscellaneous items of overhead.

"Any payments or awards made to claimants arising out of medical accidents should exclude medical costs which, in fact, were actually paid for by Medicare, Medicaid, etc. Under existing law, a successful malpractice claimant can recover for medical and hospital costs that have been paid or that will be paid in the future by Medicare, Medicaid. Such windfall payments which the government pays for directly or indirectly should cease," said Dr. Todd in the letter. He urged "a conference at the earliest mutually convenient time between representatives of the AMA and HEW to discuss the feasibility of federal legislation which would deal with the concepts discussed."

Book Reviews

Handbook of Psychiatry. 3rd edition. Philip Solomon and Vernon D. Patch (eds). 706 pages. Price, \$8.00. Los Altos, California: Lange Medical Publications, 1974.

The authors and editors of this handbook have filled the need for a concise, practical, readable and authoritative source of information for ready consultation about psychiatric problems. They have achieved the objective of winnowing out the "chaff" of conjecture and dogma from the "wheat" or useful material—separating the essential facts from the mass of complex data. This is a major task in preparing a book, as well as in the teaching and learning of the subject matter. This publication is nearly devoid of speculative or controversial data.

Tautology, prolixity and redundancy constitute a triple plague of literary blights on much of the medical literature. A frustration and a torment to student and teacher alike, these exercises in obscurantism have seemed to be particularly popular with authors and editors of textbooks in psychiatry. This imparts an esoteric quality to the subject matter of psychiatry which seems to stifle the interest of all but the most serious and highly motivated students. Even the efforts of some highly motivated teachers often appear to be futile and relatively impotent because these deficiencies are excessive in psychiatric publications. Why psychiatry as a medical specialty should be more abstruse than any other medical specialty remains to be explained.

Perhaps the editors of this handbook will consider the need for a more readable, comprehensible and esoteric textbook for beginning students and non-psychiatrist providers of health care services. The need is great. Misinterpretations, misunderstandings and misapplications of psychiatric concepts and principles are legion, perhaps largely due to the character and content of psychiatric textbooks now available.

The first edition of this handbook, published in 1969, was well received. The second edition, published in 1971, had many useful revisions and additions. This, the third edition, represents an improvement on excellence. Previously available handbooks on psychiatry were grievously deficient in one extreme or another. One such publication, *The American Handbook of Psychiatry*, consisting of three large volumes, and running to nearly three thousand pages, was surely compiled by an encyclopedist and named by a "committee." Another, *A Synopsis of Con-*

temporary Psychiatry, offers little more than the usual table of contents, and can be appreciated for its attractive cover more than for its usefulness as a source of information.

Handbook of Psychiatry is not an encyclopedia and it is not a textbook, in the usual sense, though many students and teachers may choose to use it as a textbook, considering the deplorable choices among textbooks in the field. Its authors and editors share a conviction that psychiatry is first of all a branch of medical science, and they appear to believe that the practice of psychiatry is both a science and an art as a clinical specialty of medicine. What other authors and editors of publications on psychiatry have considered psychiatry to be is often unclear and uncertain.

This edition has five-hundred additional references from recent literature. Three new chapters have been added. There is a how-to-do-it chapter on psychotherapy, developed from the authors' combined and extensive clinical experience. A chapter on psychosurgery reviews the subject and reflects upon the growing public concern about the renewed interest in surgical procedures for psychiatric illness. The chapter on transcultural psychiatry emphasizes the need for every medical practitioner to be concerned with cultural differences throughout the world and the medical implications of these differences. New sections have been added to the chapters on schizophrenia and manic-depressive disease, and a discussion on the pro's and con's of acupuncture is included to reflect the growing interest in that subject in medical circles here and abroad.

The subject matter of this book permeates all facets of daily living more than any other medical entity. That it should be an essential component of all medical education appears to need no elaboration. To avoid obfuscation and to concisely present the subject in a comprehensive, readable and practical form, free of conjecture and dogma, seems to represent the fulfillment of an important need in clinical medicine and in medical education.

WILLIAM S. PEARSON, M.D.

Handbook of Obstetrics and Gynecology. 5th edition. By Ralph C. Benson, M.D. 770 pages. Price, \$8.00. Los Altos, California: Lange Medical Publications, 1974.

This clearly written synopsis is adequately illustrated, and is updated to include recent develop-

ments in obstetric and gynecologic practice. Its stated purpose is to serve as a supplement rather than a substitute for the standard references in the specialty. The handbook meets this objective and is a condensation, rather than a degradation of information, as is so often the case with synopses.

I highly recommend this publication for medical students and practitioners in training who might need a precise but brief overview of the specialty.

RICHARD L. BURT, M.D.

NOTE: Books received which will not be reviewed:

1. **American National Red Cross: Lifesaving, Rescue and Water Safety.** 240 pages. \$2.25. New York: Doubleday & Company, 1974.
2. **New Parts for Old. The Age of Organ Transplants.** By John G. Deaton, M.D. 160 pages. \$7.40. Palisade, New Jersey: Franklin Publishing Co., 1974.

In Memoriam

Norman Oliver Benson, M.D.

On August 5, 1974, Dr. Norman Oliver Benson died in Southeastern General Hospital after an illness of several months. This final illness brought to a close his medical practice in Lumberton spanning more than 40 years.

Oliver, the only son of Dr. and Mrs. Norman Eudox Benson, was born in Morgan, Georgia, November 12, 1906. He attended Clemson College, Mercer University and the University of Georgia where he was granted his M.D. degree in 1930. After graduation, he worked as an intern in Kings Daughters Hospital in Brunswick and at Oglethorpe Sanatorium in Savannah until June 15, 1931, when he arrived at Baker Sanatorium in Lumberton to begin working under Dr. Horace Baker, Sr. He brought with him the germ of his interest in urology, and in January, 1933, he began study in the graduate school at Johns Hopkins University in Baltimore under the founder and only contemporary teacher of urology, Dr. Hugh Hampton Young.

Dr. Benson returned to Lumberton and in July, 1933, opened his office, now a landmark in Lumberton, for the practice of urology.

From 1942 until 1944 he was Chief of Surgery at the Army Hospital at Fort Leavenworth, Kansas, and thence resumed his specialty of urology at the Army General Hospital in LeMans, France, where he remained until discharged in 1946.

He then returned to Lumberton and continued to serve his patients and expand his skills, and in 1949 he was elected president of the North Carolina Urological Society. His primary interests, however, were at home in Lumberton, and it was at home that he expended his bountiful energy. From 1954 to 1965 he was Chief of Surgery, and was Chief of Staff in 1958 and 1959.

His was the role of pioneer. With diligence, integrity and devotion, he established for this community the practice of urology. He defined the limits and set the standards for his specialty and thereby helped mold the foundations of the character and quality of medical practice in this area. He provided resolute leadership for his professional colleagues and warm compassionate care to his patients.

Dr. Benson did not confine his energy to medicine, however. Throughout his life he was a talented artist, his favorite medium being wood, from which he created beautiful carvings and fine furniture.

He was familiar in other walks of the community: a Deacon in the Baptist Church and president of the Men's Fellowship; president of the Lumberton Rotary Club; and he maintained a lifelong interest in the Boy Scouts, especially the Lumberton Sea Scout Troop and the Boy's Home.

Dr. Benson is survived by his widow, Lilly Varner Benson, a daughter and son, Julia and Don, two grandsons, and Mrs. Guy Abell who was always affectionately "sister."

Dr. Benson was loved by many, criticized by some, was talented and vigorous, undaunted, affectionate and sensitive, but strong and courageous, generous and kind where kindness was needed, dashing at times, but with humility—a physician of the first order.

ROBESON COUNTY MEDICAL SOCIETY

William Myles Shelley, M.D.

William Myles Shelley, born in Atlanta, Georgia, on April 25, 1928, was the only child of Mr. and Mrs. Robert Shelley. He graduated from the North Fulton High School where he was voted "the most versatile" by his classmates, and from the Virginia

Military Institute in 1949 where he was awarded a B.S. degree.

Dr. Shelley graduated from the Johns Hopkins School of Medicine in 1953 where he remained as an intern in Pathology until joining the U.S. Air Force in 1954. After retiring from active duty as a pathologist for the U.S.A.F. Hospital, Sampson Air Force Base, New York, in 1956, he returned to Johns Hopkins Hospital for two years of Pathology residency under the guidance of Dr. Arnold Rich. The following year he went to the Memorial Hospital of New York for a year of surgical pathology under the directorship of Dr. Fred Stewart. He then returned to Johns Hopkins where he became Chief Resident in Pathology, under the clinical leadership of Dr. Ivan Bennet, and upon the completion of that year he joined the faculty of the School of Medicine and served as Chief of Surgical Pathology of the Johns Hopkins Hospital for ten years.

To the surgeon he committed himself and his laboratory staff. He totally identified with the surgical patient through the surgeon and constantly strove for closer communication between surgeon, radiologist and pathologist *and* between the operating room and the surgical pathology laboratory. These ideals ultimately resulted in the relocation and rebuilding of the Hopkins Surgical Pathology Laboratory. In addition to the surgeons with whom Dr. Shelley worked

so closely as a consultant, it is that large group of young people in varying stages of their medical education who dearly appreciated, respected and admired the teaching talents of Dr. Shelley. During this period he co-authored some 25 scientific papers and made himself available to the community, serving as a consultant to the Union Memorial Hospital, the Veterans' Administration Hospital and the U.S. Public Health Hospital in Baltimore. In 1965 he was appointed Visiting professor of Pathology at the American University of Beirut, Beirut, Lebanon.

Feeling the need for other challenges, Dr. Shelley accepted the Directorship of the Laboratory of the Charlotte Memorial Hospital where he spent four years in further developing the existing educational programs and extending the benefits of contemporary laboratory medicine into the community and region.

On October 11, 1974, Dr. Shelley died from injuries sustained in a plane crash, despite heroic medical efforts, prayers and hopes.

Surviving are his devoted wife, Betty, and their three children, Virginia, Bob, and Marty.

Dr. William Myles Shelley, a people leader, an inspiring teacher, and a giant in surgical pathology leaves a heritage that the administrators of the William M. Shelley Memorial Fund hope to pass to the future.

MECKLENBURG COUNTY MEDICAL SOCIETY

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Intra Aortic Balloon Counterpulsation in Acute Cardiogenic Shock, Thomas N. Masters, Ph.D., Norris B. Harbold, Jr., M.D., Donald G. Hall, M.D., Marvin M. McCall, III, M.D., Harry K. Daugherty, M.D., Donald C. Mullen, M.D., and Francis Robicsek, M.D.; Drug Utilization Review of Medicaid Patients: Therapeutic Implications and Opportunities, J. Heyward Hull, M.S., H. Shelton Brown, Jr., B.S., Frank F. Yarborough, B.S., and William J. Murray, M.D., Ph.D.; Mediastinoscopy in the Assessment of Operability of Bronchogenic Carcinoma, Gordon F. Murray, M.D., Benson R. Wilcox, M.D., Peter J. K. Starek, M.D. and Lewis E. Williams, M.D.; Program, 121st Annual Meeting, May 1-4, 1975, Pinehurst Hotel, Pinehurst, North Carolina, See page no. 193.

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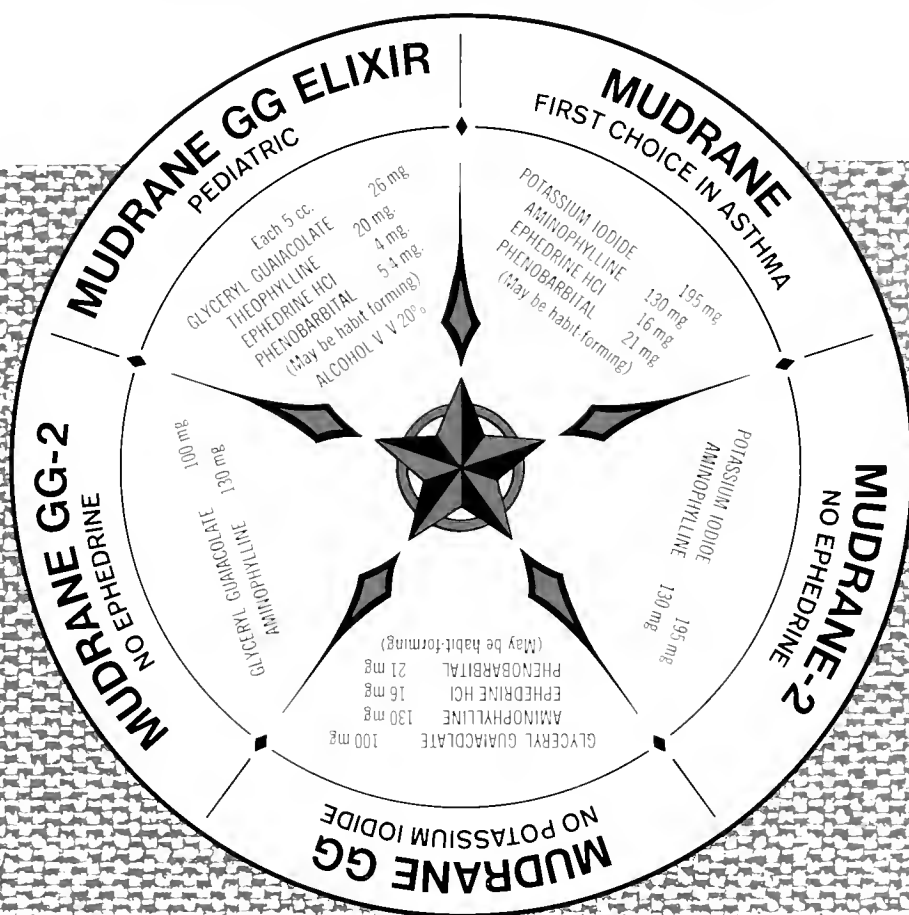
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Intra-Aortic Balloon Counterpulsation in Acute Cardiogenic Shock

Thomas N. Masters, Ph.D., Norris B. Harbold, Jr., M.D., Donald G. Hall, M.D., Marvin M. McCall, III, M.D., Harry K. Daugherty, M.D., Donald C. Mullen, M.D., and Francis Robicsek, M.D.

INTRA-AORTIC balloon counterpulsation (IABC) has been used primarily in acute myocardial infarction and shock and for circulatory support following cardiac surgery.^{1,2} Diastolic augmentation by IABC has been shown to improve cardiac performance in patients in cardiogenic shock.³⁻⁶ Diastolic augmentation (Figure 1) results from inflation, during ventricular diastole, of a balloon catheter placed in the descending thoracic aorta (Figure 2), and deflation during systole; the balloon acts as an auxiliary pump assisting forward blood flow as long as the left ventricle is functioning. It also results in increased coronary blood flow,⁷⁻¹⁰ and balloon deflation prior to systole (Figure 2) reduces left ventricular end-diastolic pressure (LVEDP) by causing a more complete emptying of the left ventricle, thus decreasing left ventricular afterload and reducing myocardial oxygen requirements.¹¹

The Myocardial Infarction Research Unit (MIRU) at Massachusetts General Hospital defines cardiogenic shock as a peak systolic ar-

terial pressure of less than 80 mmHg, a cardiac index of less than 2.1 liters/min/M², urine output of less than 20 ml/hr; perfusion of the brain and periphery diminished with concomitant signs of mental confusion or obtundation and cold clammy skin.¹² In recent reports these standards have been relaxed in order to initiate IABC earlier,^{11,13} because a reduced time interval from the onset of infarction to counterpulsation might minimize irreversible damage to the ischemic zone of the infarcted muscle.¹⁴

We have used IABC in 15 cases of myocardial infarction for "drug refractory" cardiogenic shock and in five surgical patients for circulatory support after cardiac surgery utilizing cardiopulmonary bypass. The majority of these patients received vasopressors and inotropic agents and were still in shock as defined by the MIRU criteria.

In this report, the experience of these 20 patients is presented and our future use of IABC is discussed, based on our findings and those of other investigators.

GENERAL CONSIDERATIONS

IABC was accomplished by the insertion of an Intra-Aortic Balloon Pump and trisegment balloon catheters (40, 30, or 20 ml volume),* a

major surgical procedure which should be done in an operating room. Prior to insertion, a No. 8 Dacron graft was passed over the balloon portion. The location of the catheter in the thoracic aorta was estimated externally, and a ligature was placed on the catheter at the estimated point of advancement in the femoral artery, a procedure which eliminates the necessity of fluoroscopy during placement. The catheter was advanced via the femoral artery so that the balloon portion rested in the thoracic aorta just below the subclavian artery. The Dacron graft was anastomosed to the femoral artery so that the catheter could be secured by ligatures around the graft, permitting blood flow to continue to the leg. A multichannel recorder, Model PR-7† monitored aortic root pressure, central venous pressure (CVP), ECG, and heart rate, during and after IABC.

After the surgical procedure, portable chest roentgenograms confirmed the location of the catheter. When IABC was started, we weaned most patients off pressor and inotropic agents. We removed patients from IABC by first reducing the assist volume of the balloon by 10 ml and the balloon inflation to every other beat until balloon volume was decreased by at least one-half and in-

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† Electronics for Medicine, White Plains, New York.

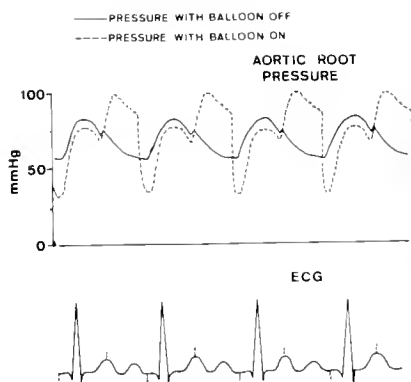


Fig. 1. Aortic root pressure with and without diastolic augmentation, ECG indicates points of inflation (dotted line above T-wave) and deflation (dotted line between P and R wave). Balloon is inflated at diastolic notch and deflated just before next systole. Pressure pulse excursion would be peak diastolic pressure over end-diastolic pressure during balloon counterpulsation.

flation occurred every eighth beat. When IABC no longer appeared necessary, the balloon was inflated manually every ten to 15 minutes to prevent clot formation on the balloon portion. The catheter was removed within several hours if the patient remained stable, the Dacron graft ligated and the wound closed.

RESULTS

The average age of all patients was 57 years (range, 37 to 73). Of 15 medical patients with myocardial infarction and cardiogenic shock, there are five long-term survivors (33 percent), whereas the use of IABC in five postoperative patients with acute myocardial failure resulted in two long-term survivors (40 percent). Our typical patient had a prepump systolic pressure of 65-70 mmHg, no diastolic pressure, oliguria or anuria, and required large amounts of vasopressors and inotropic agents. The initial response to IABC was a marked decrease in vasopressor requirements for maintaining an adequate blood pressure. The time from onset of shock to balloon insertion averaged 14 hours in the survivors and 20 hours in the nonsurvivors. All survivors in the medical group had increased urine output after six to eight hours of IABC and were easily weaned off sympathomimetic drugs. The pumping time averaged 35 hours in the

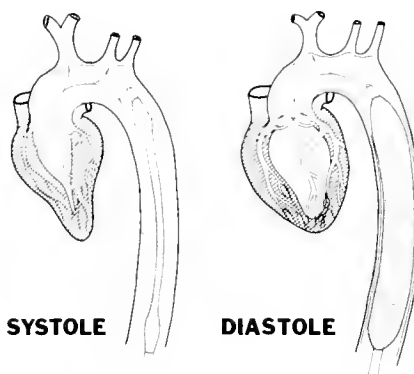


Fig. 2. Mechanism of intra-aortic balloon counterpulsation. Balloon is deflated immediately before systole, allowing left ventricle to empty more completely, thus reducing end-diastolic pressure. During diastole, balloon is inflated when the aortic valve is closed, augmenting diastolic pressure and increasing coronary perfusion pressure and flow.

survivors and ranged from one hour and 45 minutes to 98 hours in the nonsurvivors.

All but one nonsurvivor showed an increased dependence on vasopressors, and all were either oliguric or anuric initially or developed anuria during IABC (Figure 3). Figure 3 also shows the IABC period of a medical patient who did not survive and did not require increased sympathomimetic drugs; when counterpulsation was initiated he was anuric, his blood pressure was low, and he was receiving large amounts of vasopressors. After eight hours, the urine output increased temporarily but dropped markedly after 20 hours and ceased after 48 hours, with a corresponding elevation in CVP. His blood pressure increased and stabilized; when IABC was terminated his aortic pressure was 114/80 mmHg with inotropic and vasopressor support. After approximately four hours, norepinephrine was discontinued and peritoneal dialysis, begun at 40 hours, was continued. After 12 hours the patient developed atrial fibrillation, followed by ventricular fibrillation and death. The value of IABC is demonstrated by the responses of three survivors in the medical group (Figures 4-6). The patient represented in Figure 4 developed symptoms of acute myocardial infarction during surgery for a perforated gas-

tric ulcer. Her blood pressure decreased rapidly and could not be detected by routine auscultatory methods. After futile administration of vasopressors and inotropic agents, diastolic augmentation was begun. After two hours of IABC, her blood pressure was 80/35 mmHg (peak diastolic/end diastolic during IABC) with no urine output. After eight hours her urine output was good, with a systolic pressure above 100 mmHg and a marked decrease in required sympathomimetic agents. IABC was discontinued after 20 hours, with pressure stabilized at 115/80 mmHg (systolic/diastolic). This patient had no history of myocardial infarction. Figure 5 shows a similar response to IABC in a patient with a third myocardial infarction. After four hours of counterpulsation, his elevated blood pressure had decreased, and after 48 hours it was stabilized at 90/60 so that counterpulsation could be discontinued after 52 hours. He was discharged from the hospital three weeks later when his blood pressure was 110/80 mmHg.

The effectiveness of IABC in cardiogenic shock is shown in another medical patient who survived an episode of myocardial infarction (Figure 6). Although urine output and blood pressure were satisfactory after four hours of IABC, the patient required a constant infusion of vasopressors. After 16 hours a leak developed in the pumping console and counterpulsation had to be terminated so that phenylephrine and epinephrine had to be substantially increased in dose to maintain blood pressure. The pump was on intermittently, and after 18 hours it was discontinued. The requirement for sympathomimetic drugs decreased during the next 12 hours. The patient was discharged from the hospital four weeks later.

We used IABC in five out of 340 patients who underwent heart surgery in cardiopulmonary bypass during 20 months. The courses of these five patients were characterized by an inability to maintain an adequate blood pressure after bypass was discontinued, despite the administra-

tion of large amounts of sympathomimetic drugs. In four patients IABC was effective with two long-term survivors. One patient's systolic blood pressure remained at 50 mmHg despite IABC and large quantities of vasopressor and inotropic agents; she died on the operating table. She had undergone a single saphenous vein bypass graft and there was evidence of a large acute left ventricular infarct.

Another patient who underwent surgery (double saphenous vein bypass) had difficulty after the bypass was discontinued. IABC was started despite a mild aortic valvular insufficiency and the patient was removed from cardiopulmonary bypass. However, long-term counterpulsation was not effective (probably because of the aortic insufficiency) and the patient died 18 hours later.

The third patient who died in the surgical group developed left ventricular dysfunction, with a marked decrease in blood pressure, approximately 30 minutes after surgery. IABC was effective in reversing the cardiogenic shock, but the patient did not regain consciousness and died three days later.

The two long-term surgical survivors had similar difficulties coming off cardiopulmonary bypass. One had undergone mitral valve replacement and a saphenous vein bypass graft to the right coronary artery. IABC was effective and the patient was removed from bypass so that counterpulsation could be stopped after 17 hours, even though he was anuric. He recovered renal function after repeated hemodialysis and left the hospital eight weeks after surgery. The other surgical survivor had saphenous vein bypass grafts to both the left and right coronary arteries. After removing him from cardiopulmonary bypass, attempts to maintain blood pressure were ineffective and ventricular fibrillation developed. Defibrillation attempts were unsuccessful and he was returned to cardiopulmonary bypass while the balloon catheter was inserted. With IABC, the patient was easily removed from bypass, and counterpulsation was discontinued after four and one-half

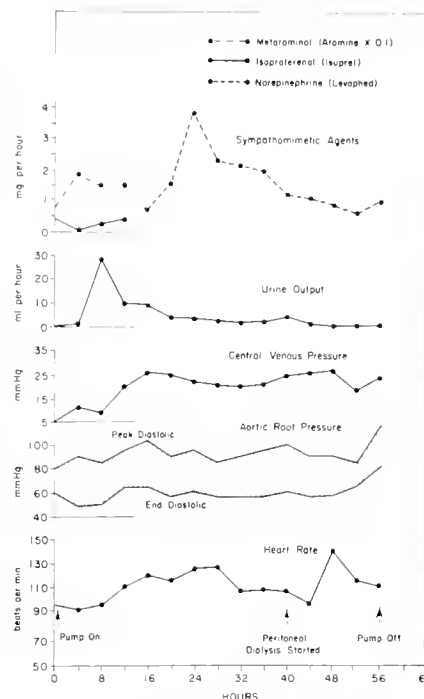


Fig. 3. Changes in vasopressor and inotropic drug doses, urine output, central venous pressure, aortic root pressure and heart rate during 56 hours of counterpulsation in a patient who died.

hours. He had an uneventful recovery and was discharged two weeks later.

COMPLICATIONS

In three patients, the balloon catheter could not be advanced into the abdominal aorta because the femoral and iliac arteries were severely atherosclerotic; IABC was not possible in these patients. In one patient, the balloon catheter entered the intima of the left iliac artery, was advanced and rested outside the intima of a preexisting abdominal aortic aneurysm. Inflation and deflation of the balloon resulted in adequate, but slightly damped, diastolic augmentation because of movement of the aneurysmal sac into the lumen of the abdominal aorta.

The most common complication, ipsilateral leg ischemia, resulted from reduced blood flow caused by the large catheter which was almost equal to the internal diameter of the femoral artery in these patients.

DISCUSSION

The basic alteration in myocardial infarction which leads to cardiogenic shock is the marked reduction or

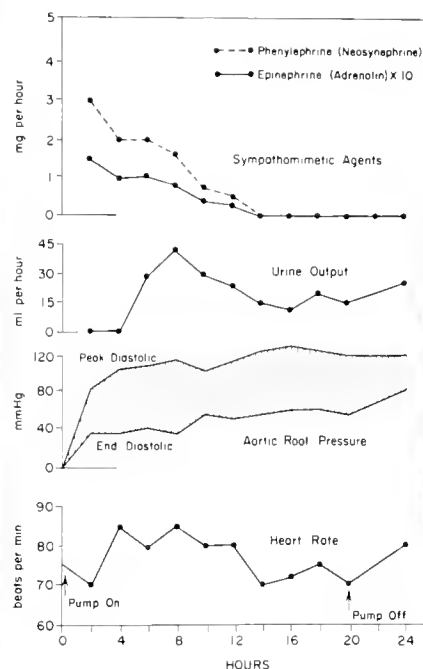


Fig. 4. Changes in sympathomimetic amine requirement, urine output, aortic root pressure and heart rate during 20 hours of counterpulsation in a patient who survived. Note the decrease in the amount of vasopressor required.

complete cessation of blood flow to approximately 50 percent of the myocardium.¹⁵ The resulting reduction in myocardial contractility and cardiac output causes a significant decrease in systemic pressure, and reflex compensation usually results in increased peripheral vascular resistance which tends to increase the left ventricular afterload and myocardial oxygen consumption. The greater peripheral resistance also reduces blood flow to vital organs already compromised by the reduced systemic flow. Lactic acidemia, acidosis and myocardial hypoxemia reduce cardiac contractility still further and potentiate this vicious "shock-cycle." The reflex mechanisms which initially increased peripheral resistance fail, causing hypotension, further metabolic deterioration and a reduction in cardiac function. Continuation of these conditions leads to irreversible shock.

The infarcted myocardium is characterized by a central necrotic area surrounded by an ischemic zone.¹⁶ Restoration of blood flow to the infarcted area within approxi-

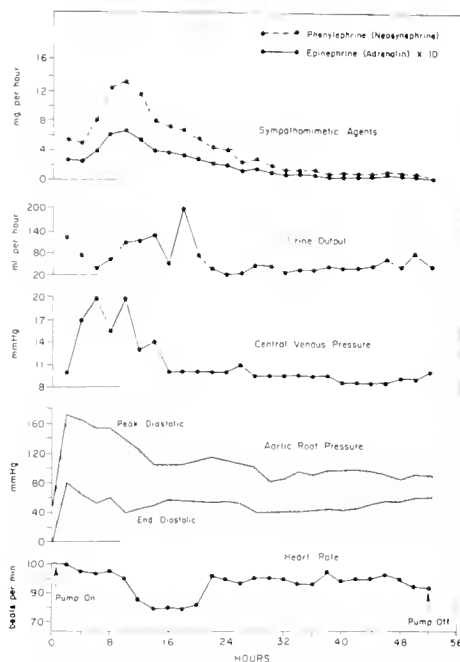


Fig. 5. Counterpulsation for 52 hours in a patient who survived. The vasopressor dose was slowly decreased and discontinued after 52 hours. The stabilized arterial blood pressure after 52 hours was below 100 mmHg (peak diastolic during augmentation).

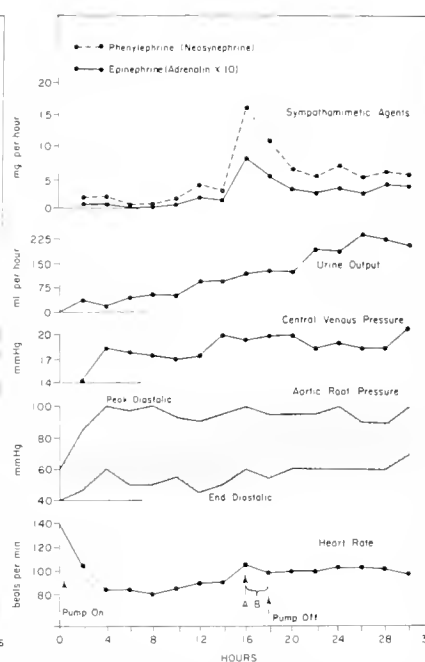


Fig. 6. Changes during diastolic augmentation in a patient with acute myocardial infarction and cardiogenic shock. After 16 hours, counterpulsation was stopped because of a leak (A). The pump was used intermittently during the next two hours (B). A marked increase in sympathomimetic agents (A) was required to maintain adequate aortic blood pressure when counterpulsation was stopped.

mately 20 minutes may completely reverse the metabolic and anatomical changes caused by ischemia.¹⁷ Since it is usually impossible to restore blood flow within this time period, it is important to salvage as much myocardium as possible. The ischemic zone enlarges for approximately 18 hours after infarction concomitant with extension of the necrotic zone which increases at the expense of the ischemic zone.¹⁶ Extension of these damaged areas results when the elevation in left ventricular afterload increases myocardial oxygen demands and oxygen availability is greatly reduced. Peripheral resistance falls, hypotension follows, coronary blood flow, resulting from decreased perfusion pressure, and oxygen availability are further reduced. Extended periods of hypotension result in extensive and permanent destruction of myocardium.¹⁵

Application of IABC may interrupt this cycle. Decreased aortic systolic pressure⁶ and balloon deflation immediately before systole

result in a more complete emptying of the left ventricle, with a reduction in left ventricular afterload and myocardial oxygen consumption. Increased diastolic pressure increases coronary blood flow,^{4, 8, 9} as well as collateral flow,¹⁸ and provides a greater oxygen and nutrient supply to ischemic and healthy myocardium, preventing the enlargement of the ischemic zone and reducing its size.^{14, 19}

If counterpulsation of any type^{6, 11, 18} is to be successful in reversing cardiogenic shock, it should be started before significant progression of ischemia and necrosis. In the present report, we found that the time from onset of shock to counterpulsation in our survivors averaged 14 hours and in our non-survivors it was 20 hours. The use of sympathomimetic drugs further increased myocardial wall tension and contractility, requiring an even greater demand for oxygen. The majority of our medical patients were refractory to vasopressor and inotropic agents and were in severe

cardiogenic shock prior to IABC; extensive irreversible myocardial damage was seen at autopsy in hearts from nonsurvivors. Earlier use of counterpulsation might have prevented this extensive damage and reduced mortality.

Jacobey et al¹⁸ have found a significant, permanent increase in the number and size of collateral coronary channels in dogs when counterpulsation, effected by an extracorporeal synchronized pump was applied early after infarction (ten minutes with two hours of pumping). When counterpulsation was started six weeks to ten months after infarct, no significant change in collateralization occurred. Since it is unlikely that counterpulsation could be applied clinically within ten minutes after infarct, 24 hours after production of ischemia would have been a better time to study collateralization. The importance of IABC in elevating coronary blood flow has been emphasized,⁷⁻⁹ but Powell et al¹⁹ have shown that the increase in coronary blood flow in dogs occurs in ischemic myocardium where autoregulation is no longer present. In nonischemic myocardium, IABC has very little effect on coronary blood flow¹⁰ or collateralization,¹⁸ suggesting a valuable diagnostic relationship.¹⁰ If severe hypotension does not exist and IABC causes an increase in coronary blood flow and oxygen consumption, a sizable ischemic area which could benefit from myocardial revascularization procedures may be present.

Pharmacological treatment of patients requiring IABC is unexplored, but glucose-insulin-potassium (GIK) infusion,²⁰ hyaluronidase,²¹ corticosteroid administration²² and propranolol²³ may be effective in reducing myocardial necrosis after infarction. A combination of IABC and any of these pharmacological applications might be synergistic in the treatment of myocardial infarction.

Because of our experience in using IABC and that of others, we think that it has a definite place in the treatment of severe myocardial

infarction and that its early use is imperative if full benefit is to be realized. It also has a definite place in helping an occasional surgical patient off cardiopulmonary bypass. Patients bordering on shock from acute myocardial infarction would have a better chance of recovery if IABC were started before MIRU criteria have been met, thereby preventing the enlargement of the necrotic zone and the ischemic damage attributed to sympathomimetic drugs used in trying to maintain an adequate blood pressure. Moreover, these patients later might be better candidates for coronary arteriography and subsequent acute myocardial revascularization procedures. Overall consideration of the patient and possible complications would have to be balanced in making the decision to start IABC earlier.

The use of IABC, combined with emergency arteriography and acute myocardial revascularization procedures, in preventing extensive myocardial damage, is still experimental but appears to be physiologically sound.

SUMMARY

The clinical use of intra-aortic balloon counterpulsation (IABC) in 20 patients with cardiogenic shock has proved the value of this technique in severe myocardial infarction and intraoperative cardiogenic shock. We have had a 35 percent (7 of 20) survival rate, and IABC was successful in reversing shock in all but two patients.

Our criteria for initiating IABC in cardiogenic shock patients have been: (1) a difficulty in maintaining systolic pressures of 70-80 mmHg with massive doses of vasopressors and inotropic agents; (2)

a very low or no urine output; and, (3) a reduction of systemic blood flow resulting in mental confusion and cold, clammy skin.

During IABC, the amount of sympathomimetic drugs necessary to maintain an adequate physiological blood pressure was markedly decreased. Urine output increased in all but one of our survivors and decreased to zero in the majority of our nonsurvivors. The most common complication was severe ischemia of the leg in which the balloon catheter was inserted.

IABC can be a valuable technique in the treatment of certain patients who have cardiogenic shock and should be started early to be fully beneficial. Using IABC with selected drugs, and in combination with acute coronary artery angiography and surgery, although still experimental, seems to be a physiologically sound application.

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I shall only say this, that you ought always to ask yourselves whether an individual in the state of apparent death might not return to life, notwithstanding the cessation of the movements of the heart and of respiration; whether the suspension of life is temporary or absolute; and I think that it will be possible in a great many cases to save the individual and restore him to life, for the simple reason that, as a result of inhibition, the blood retains its vital properties for a fairly long time.—*Death and Sudden Death*, P. Brouardel, 1897, p. 24.

Drug Utilization Review of Medicaid Patients: Therapeutic Implications and Opportunities

J. Heyward Hull, M.S.,* H. Shelton Brown, Jr., B.S.,† Frank F. Yarborough, B.S.,‡ and William J. Murray, M.D., Ph.D.§

SINCE drug therapy is a major tool of the physician, the incidence of drug-induced iatrogenic diseases has understandably become a significant problem. It has been estimated that \$3 billion a year is spent to correct adverse drug reactions.¹ Three to five percent of all hospital admissions have been attributed to drug-related problems,^{2,3} and in-hospital incidence has been estimated to range from ten to 30 percent.^{2,4-7} Melmon⁸ has suggested that 70 to 80 percent of such reactions can be predicted from knowledge of a drug's action and from a patient's history, and can be avoided without compromising the goals of therapy. If this is correct, more careful drug selection and better surveillance of drug use is indicated. From these studies several factors can predict the degree of risk for a given patient; these include the patient's age, body surface area and state of health. Diseases of the liver and kidney may alter drug metabolism and

excretion and predispose to toxicity if drug selection or dosage is inappropriate.

The frequency of drug reactions is associated with the number of drugs being taken at a given time. For example, if a patient is given six to ten drugs simultaneously, the probable adverse reaction rate is seven to ten percent; if increased to 20 drugs, the predicted reaction rate is 40 percent.⁹ The frequency of drug-drug interactions (the effects of one drug influencing the action of another) probably follows a similar pattern.

Most studies regarding the incidence of adverse drug reactions have been conducted with hospitalized patients. The impact of adverse drug reaction on non-hospitalized patients has received little attention, but systematic application of risk factors in outpatients may be feasible to screen for possible drug-related problems in large-scale state and federal programs providing prescription coverage.

Medicaid patients in North Carolina, many of whom receive multiple medications, have comprehensive prescription drug coverage. Since these patients are not hospitalized, their drug treatment cannot be easily monitored; thus, they may be a high risk group for iatrogenic

problems more difficult to detect.

PAID Prescriptions, a company specializing in prescription drug claims processing, is contracted by the North Carolina Department of Social Services to administer the Title XIX Medicaid Program for prescription drug benefits, and is required to administer a program of drug utilization review which is based upon techniques developed in a similar California program.^{10,11} North Carolina is the first state to incorporate drug utilization review into its Title XIX Medicaid coverage. In this state, six pharmacists and a physician in each of four geographical regions meet once a month to review computer printouts of recipient drug purchases. The local physicians and pharmacists involved are informed of unnecessary and inefficient drug use by a letter of inquiry and receive copies of recipients' drug profiles. The peer review system has brought about a reduction in drug costs to state and federal governments. Although many risk factors cannot be assessed by using prescription claims data, potential therapeutic problems can be identified. For example, a computer printout of medications purchased by outpatients in the California program indicated that 7.5 percent of drugs taken by 42,000 patients could have

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caused adverse drug interactions resulting in medical problems.¹²

Four types of unrecognized drug problems may be suspected from patient profiles: (1) prescription and therapeutic duplication — many patients consult more than one physician, (2) overutilization, (3) drug interactions, and (4) non-compliance. Therapeutic duplication and overutilization, which cause excessive drug purchases, are identified in the drug use review. Attempts to detect non-compliance appear not to be feasible for non-hospitalized patients, but drug interactions may be readily screened by the computer process.

The Drug Utilization Review (DUR) committees have selected oral anticoagulant drug interactions for evaluation because: (1) drugs from many pharmacologic classes interact with coumarin derivatives, e.g., warfarin, dicoumarol, and acenocoumarol, (2) they are taken for a long period of time, (3) Medicaid recipients frequently receive anticoagulant drugs and take many other medications, and (4) they have a low therapeutic index, causing discernible drug interactions.

A study by Starr and Petrie¹³

showed that of 254 outpatients receiving anticoagulants for at least six months, 85 (33 percent) were at risk for drug-drug interactions, and 42 (17 percent) bled. As confirmation, recent Medicaid profiles show patients in North Carolina taking barbiturates and warfarin simultaneously. Barbiturates stimulate enzyme induction and more rapid metabolism, necessitating an adjustment in warfarin dosage. Since its dosage is initially titrated against prothrombin time, any alteration in metabolism by the barbiturate is usually overcome by a change in warfarin dosage. However, when the barbiturate is stopped, the resulting decreased metabolic rate may cause bleeding.

When a Committee thinks an interaction might be significant, it will send the local physician an explanatory letter, a copy of the medication profile and information regarding the interaction. Feedback will be requested in the letter, but the primary goal is to make the information available to responsible physicians. If this method proves to be effective, other drug interactions will be considered for review.

The DUR Committee does not intend to dictate therapy or suppress

prescribing, but rather to inform physicians of drug use trends; methods and results of this program will be published periodically to inform local physicians and pharmacists.

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... but what we would recommend above all (for treating strains), is ease. It is more to be depended on than any medicine, and seldom fails to remove the complaint.—*William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Richard Folwell, 1799, p. 404.*

Mediastinoscopy in the Assessment of Operability of Bronchogenic Carcinoma

Gordon F. Murray, M.D., Benson R. Wilcox, M.D., Peter J. K. Starek, M.D., and Lewis E. Williams, M.D.

MORE than 50 percent of all patients diagnosed with lung cancer are inoperable when first seen. Of those patients operated upon, one-half are unresectable, and only seven or eight percent of the total group survive their disease. Surgical management of cancer of the lung must, therefore, encompass a concept of biologic operability as opposed to technical resectability. Operability implies that surgical resection offers a hope for cure. Vital to this concept is accurate assessment of the total tumor burden, i.e., the presence or absence of mediastinal lymphatic invasion as well as extrathoracic disease. The value of mediastinoscopy in assessing operability of bronchogenic cancer has been studied in 50 consecutive candidates for pulmonary resection at the North Carolina Memorial Hospital.

OPERATIVE TECHNIQUE

The operative procedure is essentially that introduced by Carless¹ in 1959. A small transverse cervical incision allows access to paratracheal, tracheobronchial and subcarinal lymph node groups (Figure 1). General endotracheal anesthesia with controlled ventilation is preferred. A plane is first developed along the anterior surface of the

trachea by careful finger dissection (Figure 2). After the mediastinal tunnel is developed, the mediastinoscope is inserted and the dissection extended under direct vision (Figure 3). The innominate artery and arch of the aorta are easily recognized anteriorly. The right radial pulse should be monitored to detect compression of the innominate and resultant compromise of cerebral blood flow. Further dissection allows exposure of the carina and proximal few centimeters of the mainstem bronchi. The azygous vein and pulmonary arteries may be readily injured. Needle aspiration is helpful in distinguishing these structures from nodes. Care must be taken to avoid injury to the left recurrent laryngeal nerve as it passes in close approximation to the trachea's left side. Bleeding is usually minimal and is controlled by pressure, cautery or silver clips. Frozen section examination of the specimen is done immediately, and positive mediastinal findings are defined in terms of cell type, location and extent of lymph node involvement. The cervical incision is closed without drainage. A portable chest film is obtained in the early recovery period to exclude a pneumothorax.

RESULTS

Mediastinal findings were positive in 13 patients (26 percent). There was a significant relationship be-

tween histologic tumor type and mediastinal lymph node metastases. Mediastinal node involvement was detected in 45 percent of patients with undifferentiated carcinoma, but in only 14 percent of patients with

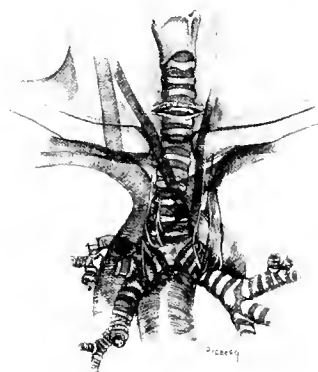


Fig. 1. A small transverse cervical incision allows access to paratracheal, tracheobronchial and subcarinal lymph node groups.

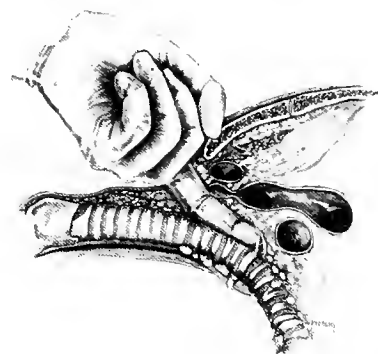


Fig. 2. A plane is first developed along the anterior surface of the trachea by careful finger dissection.

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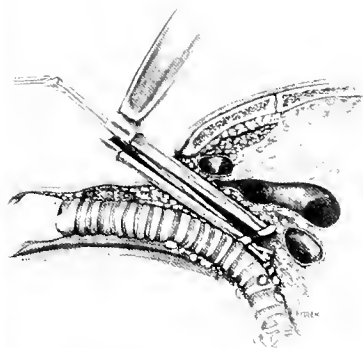


Fig. 3. Insertion of the mediastinoscope allows further dissection and biopsy under direct vision.

epidermoid carcinoma. Of the 13 patients with mediastinal metastases, large or small cell undifferentiated cancer was present in ten (Table 1). Contralateral or high pretracheal lymph node involvement was found in nine of the 13 patients. Six of the 13 demonstrated perinodal metastasis with fixation. Ipsilateral squamous metastasis was noted in only one patient.

Thirty-four of the patients with negative findings at mediastinoscopy underwent thoracotomy (Table 2), and resection for cure was accomplished in 29 patients (85 percent). Three-fourths of the resected patients in whom mediastinoscopy was negative had negative operative findings in terms of lymph node metastases (Table 3). Only one of 17 patients with primary cancer on the right had microscopic lymph node metastasis following negative mediastinoscopy. Six of 12 patients with left-sided lesions had hilar lymph node involvement despite negative mediastinoscopy; also, irresectability following negative biopsies occurred more often with left-sided lesions. Of 11 patients with positive biopsies who were followed for one year, eight have died, whereas only two of 11 patients with negative biopsies have died after one year (Figure 4). Only five negative mediastinoscopy patients died, and 17 are alive and well two to 18 months (mean, nine months) following resection.

The morbidity of the mediastinoscopy procedure was minimal and no deaths occurred in this series. Two episodes of bleeding were managed by compression through the

mediastinoscope and did not require thoracotomy. Pneumothorax, recurrent laryngeal nerve injury and infection were not seen.

Table 1 Positive Mediastinoscopy 13 Patients (26%)	
Nature of Spread	No. Patients
Undifferentiated Carcinoma	10/13
Contralateral or High Pretracheal	9/13
Perinodal Fixation	6/13
Ipsilateral Squamous	1/13

Table 2 Negative Mediastinoscopy 37 Patients	
Thoracotomy	34 Patients
Resection	29 Patients
Resectability Rate	85%

DISCUSSION

Selectivity in the surgical treatment of cancer of the lung is necessary to avoid unwarranted exploratory thoracotomy or useless pulmonary resection. There is accumulating evidence that involvement of superior mediastinal lymph nodes may be an indication of inoperability in bronchogenic carcinoma.² Paulson and Urschel³ point out that the six percent five-year survival in such cases is balanced by the operative mortality. Similar survival statistics are reported by Bergh and Schersten,⁴ who make the important observation that perinodal metastasis with invasion of the lymph node capsule adversely affects the prognosis. The ominous implications of positive mediastinoscopy are apparent in the current study (Figure 4). Of the 13 patients with positive biopsies, only four survived, whereas

ONE YEAR SURVIVAL IN 22 PATIENTS
WITH LUNG CANCER
Influence of Positive Mediastinoscopy*

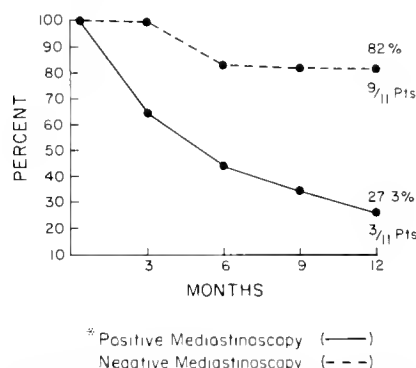


Fig. 4. One year survival in 22 patients with lung cancer; influence of positive histology at mediastinoscopy.

17 of the 26 patients who survived a resection are free of disease. Kirsh et al⁵ have reported a 29.5 percent five-year survival rate in 17 patients with epidermoid carcinoma and mediastinal metastasis treated by resection and postoperative radiation therapy. In this series, undifferentiated carcinoma was usually found in the mediastinum, and perinodal metastasis with fixation of tumor was frequent (Table 1). Epidermoid intranodal metastasis was noted in one of our patients who is alive 15 months after having pulmonary resection without evidence of recurrence.

The prognostic value of negative mediastinal exploration is also well demonstrated in the present study. Eighty-five percent of the patients with negative findings at mediastinoscopy were successfully resected (Table 2). Prior to selection by mediastinoscopy, the resectability for bronchogenic cancer in our institution was 65 percent.⁶ This im-

Table 3 Determination of Regional Lymph Node Metastasis*			
Patient Group	(a) Surgical Evaluative Classification	(b) Post-Surgical Treatment Classification	Percent
Right-sided Primary	Negative 17 pts	Negative 16 pts	94%
Left-sided Primary	Negative 12 pts	Negative 6 pts	50%
Total Lesions	Negative 29 pts	Negative 22 pts	76%

* After American Joint Committee for Cancer Staging and End Results Reporting,
(a) mediastinoscopic biopsy
(b) examination of the resected specimen.

provement in selectivity was evaluated statistically by summed binomial probability and found to be significant ($p < 0.05$). In the preferred terminology of the American Joint Committee for Cancer Staging and End Results Reporting,⁷ the surgical evaluative assessment (mediastinoscopy) accurately reflects the postsurgical treatment classification (examination of the resected specimen) (Table 3). Only one of 17 negative mediastinoscopy patients with primary cancer on the right had microscopic evidence of lymph node metastasis on pathologic examination. Accurate assessment of left-sided lesions is more difficult because of the interposition of the aortic arch. Anterior mediastinal nodes about the great vessels and subaor-

tic window lymph nodes are inaccessible at mediastinoscopy. Parasternal mediastinal exploration combined with mediastinoscopy has been recommended for patients with left hilar and left upper lobe lesions.²

SUMMARY

Selection of surgical treatment based on assessment of mediastinal lymphatic metastasis has avoided unwarranted thoracotomy and has improved resectability. Patients with undifferentiated carcinoma in superior mediastinal nodes or perinodal lymph node metastasis, or both, are not candidates for surgical resection. Mediastinoscopy is a valuable tool in the treatment of bronchogenic carcinoma, and it should be performed in all patients presumed

to have operable carcinoma of the lung.

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Editorials

MIDWINTER EXECUTIVE COUNCIL MEETING, OR MEDICINE AS THEATER

If some dramatists and lesser writers have conceived of medicine as theater—as attested by the creations for television of Marcus Welby, Dr. Kildare and the sincere, authoritative peddler of Preparation “H,” the physician-player is entitled to a few comments about his role and to thoughts about why he is on stage so often. Certainly those who attended the midwinter meeting of the Executive Council of the State Society in Raleigh, February 2, 1975, must have at times wondered who was determining when and where doctors entered and how to avoid collision on exit. Controlling such traffic requires a director with finesse and stage sense, and it is difficult for us to know who is in charge.

For example, the dimensions of the stage are not always the same, although the script may be: each federal, state or private medical program seems to divide North Carolina into different regions, even when they may have similar aims, objectives and forms. As indicated by Dr. Archie Johnson, the governor's advisor about things medical, some impetus toward clarification may come as a result of the signing of PL 93641—National Health Planning and Resources Development of 1974—which requires the state to canvass and consult any organization involved in health service in an effort to improve our design and offer better health services. Comprehensive health planning, activities coming under the Hill-Burton Act and the Regional Medical Program, will now be part of the same production, and medical education may be given some cues about where to enter and when to expect an intermission. An ad hoc committee to work with Dr. Johnson was appointed by Dr. Frank Reynolds, Society president; they face difficult decisions, deadlines and probably deadlocks, and deserve all our support and forbearance.

The Committee on Legislation (Dr. H. David Bruton, chairman) was longest in the limelight, reflecting increasing activity on this stage, called government, and in the wings where legislation is hammered out in response to need and fashion. Since fewer than a dozen insurance companies remain in the medical liability field, the Committee has been observing it carefully; they reported that a bill would be introduced in the Legislature in early February requiring insurers writing general liability policies to participate in a professional liability reinsurance pro-

gram similar to the pool devised for compulsory auto insurance. After detailed discussion, the Council voted to support the proposal, while recognizing certain limitations in its design. In response to the request of the Board of Medical Examiners, the Council endorsed an amendment to the North Carolina Medical Practice Act to require all applicants for licensure in the state to complete satisfactorily one year of postgraduate clinical training; another was endorsed empowering the Board to subpoena medical records having to do with patient care, and to have access to such records. The Council, however, did not endorse an amendment to the act which would allow physicians' assistants and certain registered nurses to prescribe drugs, fearing a Pandora effect, while recognizing the need for improving services in sparsely populated areas. It did approve a minor's consent law, on the advice of the Committee, and urged continuing state financial support of medical student programs in family practice and primary care.

After hearing Dr. M. Frank Sohmer's report on the progress of the North Carolina Medical Peer Review Foundation, Inc. establishing a position “that acupuncture therapy should be regarded as the practice of medicine in an experimental phase, permissible only in qualified investigational settings,” referring a number of proposals to appropriate sections or committees and tabling others, and accepting several reports and other information, the Council adjourned, but knowing it is still under the spotlight.

DISSONANCE AND DISEASE

For close onto forty years it has seemed to me that some sorts of music were unphysiologic. Perhaps the fact that the dog howled when certain kinds of putative music were being played on the piano or harmonica planted the idea, or it might have been a personal reaction—at any rate, the idea has persisted. Not that I've made no effort to understand the tonerow and 12-tone crowd; I've gone the extra mile and listened to the learned among the electronic school tell how they do it, but what they turned out never impressed me as being music. Technical virtuosity? Engineering skill? Yes—but bearing the relation to art that wallpaper design does.

Now along come some Germans (naturally) who have shown medical side effects of contemporary music on those who play it. Thus far I've only seen their work reported by Harold Schonberg, the

New York Times' music critic, so it's hard to assess their results; but since I'm ready to believe them, here they are, for those whose local papers might not have carried the news. The 208 musicians studied had such complaints as nervousness, irritability, aggression, insomnia, earaches and impotence. Leaving out the latter, I've heard the same things voiced by departing concert-goers exposed to such as Cage, Stockhausen and Penderecki. I hope additional work, done with Teutonic care, will come forth from the land of Brahms and Beethoven. Although it may be that *their* contemporaries among performers and listeners had similar physiologic effects, it's hard to believe. For physicians, another question now goes into the computer of the artful historian—have you been listening to the synthesizing of the Moog lately?

R.W.P.

DRUG UTILIZATION REVIEW

Booming drug development by the pharmaceutical industry has been matched stride for stride by drug consumption in our drug-oriented society. The practitioner continues to bear the brunt of this bi-directional demand for drug utilization, and it remains his medical, legal and ethical responsibility to ensure that drugs are prescribed in a rational manner.

Increased usage, particularly of potent new agents, can be expected to increase the incidence of adverse

drug reactions and interactions. Many recent studies indicate clearly that the significant number of adverse drug reactions are predictable and related to pharmacologic properties of the offending agent(s), and that the incidence is correlated with the number of drugs being taken.

Hull et al (this JOURNAL, page 162) have proposed a physician/education warning system to decrease adverse drug interactions using computerized data from the drug utilization review program (under the aegis of PAID Prescriptions, a company under contract to process prescription drug claims under the North Carolina Medicaid Program). Assuming that this surveillance mechanism, to determine patient use of drugs which are high risks for adverse interaction, would entail no additional costs, it should be educational for the physician and beneficial to the patient.

The authors suggest that outpatients, who are not monitored as closely as hospitalized patients, are at higher risk for adverse drug occurrences. However, outpatients are usually less ill and receive fewer drugs. The Boston Collaborative Drug Surveillance Program,¹ indicates that the incidence of significant drug reactions (requiring subsequent hospitalization) in outpatient populations is less than that of patients already hospitalized and that drugs are generally safe in consideration of serious or fatal reactions. None-

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theless, the surveillance system suggested by Hull et al should be a valuable asset to North Carolina physicians if used wisely.

If the North Carolina program is to be effective it should be able to issue an adverse drug reaction warning far more rapidly than the four to six weeks suggested by the authors. Review by a panel which meets once monthly would result in dangerous delays, and although the review panel's commentary might reinforce what the physician learned the hard way, in most instances it would be of little worth to patients. A panel of experts in human pharmacology should be carefully selected to evaluate, compile and keep current a list of adverse drug interactions. Many publications describing drug interactions report a large percentage based on data which are anecdotal, poorly documented, or inferred from animal experimentation. The DUR Committee's selection of oral

anticoagulants as a feasible prototype is the classic exception to this observation. Legal evaluation of accessibility to information compiled by the proposed system should be undertaken prior to its implementation, because misinterpretation of easily accessible data by unauthorized persons could lead to litigation aimed at conscientious physicians.

The authors should be commended for their efforts to initiate a program aimed at educating the physician and protecting the patient. We, as physicians, owe it to our patients to support such goals, and to our profession to undertake our responsibility with judicious care.

JOHN S. KAUFMANN, M.D., PH.D.

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Correspondence

PRESCRIPTION LABELING

To the Editor:

Last spring the General Assembly passed Medical Society sponsored legislation requiring pharmacists to label prescriptions with the name and strength of medication. So the frustrating hours of delay spent fumbling through the PDR, sniffing bottles of syrup, and rousing sleeping druggists in "emergencies" should have come to an end. But physicians retained the option of requesting that drug identities be withheld. Since old myths die hard, the problem persists.

Recently, expecting a green elixer to be identified, I waited two hours for a pharmacy to open, to be told by the pharmacist that the prescribing physician had left standing orders that none of his prescriptions were to be dispensed with names. The doctor confirmed this, reciting, "We want to discourage self-medication and patient prescribing."

It's a time honored excuse, but what evidence is there that knowing the name of a medication increases these practices? We all have patients who make a smorgasbord of the medicine cabinet at the

first sign of a cold, or who eagerly share their favorite antibiotic with a neighbor. These patients rarely "prescribe" by name, but rather by color, taste and desired effect. Withholding label information does little to change these abusers.

More importantly, whether we like it or not, when patients have purchased a drug at our suggestion, they have the right to know what they've bought. Would anyone willingly gulp down an unidentified bottle of pills prescribed by someone deliberately concealing their identity?

The arguments against prescription labeling are bad. Reasons to promote the practice are compelling. The inconvenience to physicians and hazard to patients created by unidentified prescriptions degrade the health profession. We cannot allow irrational myth to destroy the progress we are making toward sane, scientific practice.

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Wake Memorial Hospital
Raleigh, North Carolina 27610

Emergency Medical Services



HISTORY OF THE UA/EMS: THE UNIVERSITY ASSOCIATION FOR EMERGENCY MEDICAL SERVICES

**Carl Jelenko, III, M.D., Chairman,
Publications Committee, University Association
for Emergency Medical Services**

The University Association for Emergency Medical Services was created in Denver, Colorado, on November 18, 1970. The major objective of this association of university physicians was the "improvement in the quality of care of acutely ill and injured." They felt that this organization should be comprised primarily of "physicians of university or university-affiliated hospitals" holding "medical school faculty appointments," and "continuing to participate actively in the field of emergency medical care and services." Representatives from 96 of 119 medical schools in the United States and Canada attended this organizational meeting; their unanimity of support for the body was obvious.

The Association determined to collect and disseminate information about the operation of emergency medical services, provide a forum for discussion of problems and proposing solutions in emergency

medical care to aid the membership in planning, administration, and provision of emergency care, and to foster education and research. It has had yearly meetings since in Ann Arbor, Michigan; Washington, D. C.; Hamilton, Ontario; and Dallas, Texas, with increasing participation at each. The Association has issued guidelines for the education of physicians at all levels of emergency medicine and for the design and function of an emergency department. The current emphasis of the UA/EMS, and perhaps its most unusual feature, is in the areas of educating physicians in emergency medical care and of coping with the special problems of the emergency physician in an academic setting. The potential and responsibility of this organization are obvious to those who are interested in emergency medicine.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," AMA Commission on Emergency Medical Services, Volume 3, No. 12, John M. Howard, M.D., Editor. Original article may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

Camargo, Carlos Enrique, M.D. (AN), 5626-B Landmark Dr., Charlotte 28211
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Gehlbach, Stephen Hunter, M.D. (PD), 2717 Royster Rd., Raleigh 27608
Hamilton, Robert William, M.D. (IM), Bowman Gray, Winston-Salem 27103
Hiatt, Wilks Otto, Jr., M.D. (P.D.), Box 68, Yadkinville 27055
Johnson, Mary Marvin (Student), 1900 Queen St., Apt. C-2, Winston-Salem 27103

Kelling, Douglas George, Jr., M.D. (Intern-Resident), 4011 Deepwood Circle, Durham 27707
Lewis, Richard Gordon, M.D. (OPH), 701 Professional Dr., New Bern 28560
MacCormack, John Newton, M.D. (PH), P. O. Box 2091, Raleigh 27602
Martin, Donion Randolph, M.D. (OBG), 527 Maple Ave., Reidville 27320
Mountjoy, John Robert, M.D. (OTO), 1140 Englewood Dr., Winston-Salem 27106
Oliver, Richard Wayne, M.D. (P), 2408 Clark Ave., Raleigh 27605
Patel, Kanchanalal B., M.D., (FP), Route 4, Box 855, Madison 27025
Powell, David Clifton (Student), 601 Chateau Apts., Chapel Hill 27514
Serafin, Donald, M.D. (PL), Duke Medical Ctr., Durham 27710

Shetterly, Roger Davis, M.D. 708-D N. Fleming St., Hendersonville 28739
 Suh, Sang Hyon, M.D. (GS), P. O. Box 266, Morganton 28655
 Turner, Jack Cocke, M.D. (Intern-Resident), 2631 Alderney Lane, Winston-Salem 27103
 Weinstein, Robert Harvey, M.D. (P), 1404 Medical Center Dr., Wilmington 28401
 Wells, James Shelton, Jr. (Student), 803 Branch St., Chapel Hill 27514

WHAT? WHEN? WHERE? In Continuing Education

March 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

Programs in North Carolina

March 16-18

Neurosciences Seminar: Fundamentals and Recent Advances in Biological Psychiatry
 Sponsors: Department of Psychiatry and the Veterans Administration Hospital, Duke University Medical Center
 Fee: \$100
 Credit: 15 hours
 For Information: John L. Sullivan, M.D., Assistant Professor of Psychiatry, Veterans Administration Hospital, Durham 27705

March 17-21

Tutorial Postgraduate Course: Radiology of the Gastrointestinal Tract
 Place: Governors Inn, Research Triangle Park (between Durham and Raleigh, near the airport.)
 Program: Designed for radiologists, but open to other physicians in training or practice. Emphasis on personalized, tutorial type teaching, with ample opportunity for discussion. Two 1 hour 20 minute tutorial sessions each morning, and one in the afternoon; 12 registrants will join one faculty member in a separate quiet room with viewboxes for organized film reading-discussions and case presentations. Each registrant will have a total of 14 different tutorial sessions. One hour "Panel" presentation-discussion each afternoon. Guest faculty include: Drs. Charles A. Bream, Harley C. Carlson, Joseph T. Ferrucci, Jr., Roscoe E. Miller, Jerry C. Phillips, Bernard S. Wolf, and, from Kings College Hospital, London, England, Dr. John Laws, Chairman, Department of Radiology.
 Fee: \$300; enrollment limited
 Credit: 28 hours
 For Information: Robert McLelland, M.D., Department of Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 19-20

4th Annual Cancer Registry Symposium — In addition to liaison physicians, cancer registrars and medical records librarians of the participating hospitals, others working in the field of cancer are invited to attend.
 Place: Crabtree Howard Johnson, Raleigh
 Sponsors: North Carolina Central Cancer Registry; North Carolina Regional Medical Program; North Carolina Division of the American Cancer Society
 For Information: Mr. Cory Menees, Cancer Program Manager, Division of Health Services, Chronic Disease Branch, P. O. Box 2091, Raleigh 27602

March 19-22

North Carolina League for Nursing Annual Meeting
 Place: Sir Walter Hotel, Raleigh

Sponsors: NCLN and the National League for Nursing
 For Information: Ms. Marie Robeson, Director of Nursing, Watts Hospital, Durham 27706

March 23-26

Conference on Maternal and Child Health, Family Planning and the Handicapped Children—focuses on latest developments in services for mothers and children
 Place: Carolina Inn, Chapel Hill
 Sponsors: Region IV Office, HEW; State Public Health Departments in Region IV; UNC School of Public Health
 For Information: Sidney S. Chipman, M.D., UNC School of Public Health, Chapel Hill 27514

March 25-26

The Problem-Oriented Record System
 Through a video-tape simulated case presentation, participants will be involved in learning to use the PORs through actual involvement
 Fee: \$50; James M. Johnston Awards available
 Recognition: 12 contact hours; NCSNA CERP
 For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 25-27

Cardiac Arrhythmia Course
 Place: Orthopedic Clinic, Room 1367
 Fee: \$85
 Credit: AAFP credit applied for
 For Information: Galen Wagner, M.D., Department of Medicine, P. O. Box 3327, Duke University Medical Center, Durham 27710

March 27-28

The Nursing Audit
 Designed to assist nursing administrative personnel in evaluating the quality of patient care through use of systematic auditing techniques
 Fee: \$50; James M. Johnston Awards available
 Recognition: 13 contact hours; NCSNA CERP
 For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

March 28

9th Malignant Disease Symposium—Childhood Malignancy
 Place: Berryhill Hall, UNC School of Medicine, Chapel Hill
 Sponsors: Department of Pediatrics and The Office of Continuing Education
 Fee: \$35
 Credit: 5 hours; AAFP approved
 For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 28-29

Eleventh Annual E. C. Hamblen Symposium in Reproductive Biology and Family Planning
 The program is designed for practitioners and residents in Obstetrics and Gynecology. There will be three basic themes: "Fertility: Enhancement and Inhibition"; "Advances in Perinatology"; and "Human Sexuality: Problems that Confront the Gynecologist."
 Fee: \$60; no charge for residents or students
 For Information: Charles B. Hammond, M.D., P. O. Box 3143, Duke University Medical Center, Durham 27710

April 1 & 2

Religion and Psychiatry: Conflicts and Harmonies
 Place: April 1—Holiday Inn, Asheville
 April 2—Holiday Inn, Cherokee
 Sponsors: April 1—HEC-WNC; Blue Ridge Mental Health Center
 April 2—HEC-WNC; Smoky Mountains Mental Health Center
 Program: The special program guest will be Dr. Bernard Harnik of Switzerland, who is internationally known for his work in marriage and guidance counseling
 For Information: Health Education Commission of Western North Carolina, P. O. Box 7607, Asheville 28807

April 4-5

Practical Pediatrics; Postgraduate Course in Pediatrics
Place: Babcock Auditorium

Sponsors: Division of Health Services, N. C. Department of Human Resources; Department of Pediatrics and Division of Continuing Education, Bowman Gray School of Medicine

Fee: \$35; includes social hour and banquet

Credit: 12 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 7-11

Practical Approaches to Diabetic Care

Program especially suitable for nurses caring for large numbers of diabetic patients. Emphasis on teaching needs of diabetic patients and how to meet them.

Fet: \$125; James M. Johnston Awards available

Recognition: 35 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 10

Rheumatoid Arthritis—10th Annual Wilson Memorial Hospital Postgraduate Symposium

Sponsors: Wilson County Medical Society and the North Carolina Academy of Family Physicians

Speakers will include Dr. John Davis, University of Virginia Medical Center, Dr. Donald McCollum, Duke University Medical Center, Dr. Edwin Martinat, Bowman Gray School of Medicine and Dr. Carwile LeRoy, Columbia-Presbyterian Medical Center

For Information: A. Tyson Jennette, M.D., Wilson Memorial Hospital, 1705 South Tarboro Street, Wilson 27893

April 11

North Carolina Diabetes Association Eighth Annual Scientific Session

The program will include a scientific session for physicians and a separate and concurrent session for laymen.
Place: Babcock Auditorium

Sponsors: American Diabetes Association, North Carolina Affiliate, Inc.; Division of Continuing Education, Bowman Gray School of Medicine

Fee: \$35; includes social hour and banquet

Credit: 6 hours; AAFP approved

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 12-13

The 1st Annual Arthritis Symposium

Place: Carolina Inn, Chapel Hill

Sponsors: Division of Rheumatology and Clinical Immunology, Department of Medicine; Office of Continuing Education, UNC School of Medicine

Fee: \$50

Credit: AAFP credit applied for

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 18

Behaviorism and Psychoanalysis Seminar

Place: Babcock Auditorium Time: 9:30 a.m.-4:00 p.m.

Credit: 5 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 21-22

Primary Nursing

Participants will explore the use of the primary system and its relationship to other systems, and identify its influence on the nursing process, patient care and staffing.

Fee: \$50; James M. Johnston awards available. Enrollment limited to 32 RN's

Recognition: 12 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdose; strictly observe contraindications, warnings and precautions for atropine, use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsful (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdose may cause severe, even fatal, respiratory depression. Signs of overdose include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Medical Department, Box 5110,
Chicago, Illinois 60680

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April 21-24

Recent Advances in Allergy
Place: The Homestead, Hot Springs, Virginia
Seminar sessions will be held from 8:00 to 10:00 on each of these four days.
For Information: Claude A. Frazier, M.D., Building 4, Doctors Park, Asheville 28801

April 23-25

The Nurse: Planning Classes for Expectant Parents
Designed to assist nurses to conduct classes for parents in prepared childbirth.
Fee: \$75; James M. Johnston Awards available up to one-half of fee, based on need. Registration limited to 16 nurses.
Recognition: 18 contact hours; NCSNA CERP
For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 24

Infectious Disease: Craven-Pamlico Annual Medical Society Symposium
Place: Ramada Inn, New Bern
Sponsor: Craven-Pamlico Medical Society
Fee: Participants and their spouses will be guests of the Society for the Symposium, including the social hour and banquet
Credit: 5 hours; AAFP credit approved
For Information: Zack J. Waters, Jr., M.D., Box 1089, New Bern 28560

April 29-May 2

Leadership for the Health Professional
Place: Lambuth Inn, Lake Junaluska, Waynesville
Sponsors: WCU Department of Nursing; Health Education Commission of Western North Carolina
Registration: limited to approximately 24; priority given to Directors of Nursing or their designees
For Information: HEC-WNC, Post Office Box 7607, Asheville 28807

May 1-4

121st Annual Session of the North Carolina Medical Society; General Session on Scientific Subjects and Specialty Section Meetings
Place: Pinehurst Hotel and Country Club
For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

May 6 & 8

Toward More Effective Diabetic Teaching
Place: May 6—Holiday Inn, Reidsville
May 8—Town & Country Restaurant, Williamston
Fee: \$24 (includes lunch); James M. Johnston Awards available
Recognition: 6 contact hours; NCSNA CERP
For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 7-14

Medical Seminar Cruise
Place: Sailing from Charleston, South Carolina and calling on the ports of San Juan and St. Thomas.
Sponsors: North Carolina Medical Society; South Carolina Medical Society, Division of Continuing Education of the Medical University of South Carolina
Fee: \$100 deposit to insure reservation; cabin rates from \$360 to \$640
Credit: 22 CE units
For Information: Medical Seminar Cruise, Southern International Travel Corporation, P. O. Box 19372, Raleigh 27609

May 8-10

Eighth Annual Workshop on Arterial Metabolism Research
Place: Babcock Auditorium
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 12-13

Family Planning Seminar
Place: Old Well Room, Carolina Inn, Chapel Hill

Sponsors: Department of Obstetrics and Gynecology, UNC School of Medicine, Office of Continuing Education, UNC School of Nursing
Fee: \$50; James M. Johnston Awards available for nurses
Credit for physicians: 11 hours; AAFP approved
Recognition for nurses: 11 contact hours; NCSNA CERP
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514 or Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 12-16

The Nursing Process
Fee: \$112; James M. Johnston Awards available
Recognition: 28 contact hours; NCSNA CERP
For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 13-14

Breath of Spring, '75—Respiratory Care Symposium
Place: Babcock Auditorium
Sponsors: Northwestern Lung Association; Division of Continuing Education, Bowman Gray School of Medicine
Fee: \$25
Credit: 12 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 23

Perinatology Postgraduate Course
Place: 103 Berryhill Hall
Sponsors: Department of Pediatrics; Office of Continuing Education
Registration: pre-registration requested
Credit: AAFP credit applied for
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 28-29

Endoscopy Workshop
Place: Berryhill Hall
Sponsors: Department of Medicine and The Office of Continuing Education, UNC School of Medicine
Fee: \$75
For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

May 28-29

26th Annual Scientific Sessions of the North Carolina Heart Association
Place: Winston-Salem Hyatt House and Convention Center
Fee: Physicians and Medical Scientists \$20; Other, \$10, except no fee for students, interns and residents. Registration fee includes cost of banquet and breakfast.
Credit: 5 hours; AAFP credit applied for
Note: Special sessions for nurses, for cardiology technologists and for volunteers.
For Information: Norris B. Harbold, M.D., North Carolina Heart Association, P. O. Box 2408, Chapel Hill 27514

July 21-26

Postgraduate Course in Radiology
Place: Atlantis Lodge, Atlantic Beach (near Morehead City)
Fee: \$150; designed for radiologists, but open to all physicians. Enrollment limited to 75
Credit: 30 hours
For Information: Robert McLelland, M.D., Department of Radiology, P. O. Box 3808, Duke University Medical Center, Durham 27710

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop
Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
Sponsors: Divisions of Continuing Education, Bowman

Gray, Duke, and UNC Schools of Medicine, and the Medical College of South Carolina

Fee: \$100

Credit: 20 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

March 19—1 p.m., "Heart Sounds"

2 p.m., "Respiratory Intensive Care"

March 26—1 p.m., "Cancer of the Colon"

2 p.m., "Care of the Cancer Patient"

April 2—1 p.m., "Intravascular Catheterization Technique"

2 p.m., "Intravascular Catheterization Technique"

April 9—1 p.m., "Cancer Chemotherapy"

2 p.m., "Stroke Rehabilitation"

April 16—1 p.m., "Genital Urinary Infection"

2 p.m., "Drug Abuse Rehabilitation"

April 23—1 p.m., "Inhalation Therapy"

2 p.m., "Intractable Angina"

April 30—1 p.m., "Solitary Pulmonary Nodule"

2 p.m., "Depression"

As this schedule has been subject to some change in the past, it might be advisable to check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)

Oteen—Stewart Scott, M.D. or Mary Ellen Lutz, R.N. (298-7911)

Salisbury—Mr. Dante Spagnolo (636-2351)

Seminars in Cardiology

March 18—Management of Arrhythmias Complicating Acute Myocardial Infarction

April 15—Recognition and Management of Complications Following Acute Myocardial Infarction

May 20—Rehabilitation Following Myocardial Infarction

June 17—Exercise Testing

Place: C. J. Harris Hospital, Sylva

Program: Physicians who will be in attendance are encouraged to refer any of their patients who present unusual treatment problems. During the morning patients will be seen by a consulting cardiologist from the UNC or Bowman Gray Schools of Medicine, and by other physicians. The first part of the afternoon will consist of case presentations, and a lecture pertaining to the specific disease entity on which the respective seminar is focused. The last part of each seminar afternoon will consist of a lecture and demonstration in Electrocardiography

Sponsors: Jackson County Medical Society; Health Education Commission of Western North Carolina

Credit: AAFP credit applied for

For Information: Ralph S. Morgan, M.D., Box 668, Sylva 28779

Nursing Equivalency Exams Available

The North Carolina Nursing Equivalency Examinations, "designed to give licensed practical nurses and other individuals an opportunity to get college credit toward the first year's work in an Associate Degree (ADN) Program," are now available at six College-Level Examination Program test centers in North Carolina.

To apply, contact one of the following: Dr. D. W. Proctor, Dir. of Guidance, Gardner-Webb College, Boiling Springs 28017; Mrs. J. G. Bailey, Dir. of Testing, East Residence Hall, ASU, Boone 28607; Dr. R. B. Simono, Dir., Counseling Center, UNC, Charlotte 28202; Dr. L. M. McManus, Jr., Dir., Counseling Center, Fayetteville State University, Fayetteville 28301; Miss E. Saunders, Dir., Guidance & Placement, Methodist College, Fayetteville 28301; Mr. R. K. White, Counselor, NCSU, Box 5505, 210 Peele Hall, Raleigh 27607.

Developed by the North Carolina Regional Medical Program in cooperation with the College Entrance Examination Board and Educational Testing Service, the examina-

tions were made possible by grants from the United States Public Health Service and the Kate B. Reynolds Health Care Trust.

For an informational booklet of "descriptions, sample questions and score information" contact: College Board Publications Orders, Box 2815, Princeton, New Jersey 08540

Programs in Contiguous States

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

May 12-15

Cardiology for the Internist

Place: Royal Couch Motor Hotel, Atlanta, Georgia

Sponsors: American College of Cardiology; Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine, Atlanta, in cooperation with Georgia Heart Association

For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

May 12-16

Family Practice Review Program: The College of Medicine, Division of Postgraduate Education, University of Florida has extended to North Carolina physicians a special invitation to participate in this particular program.

Place: Gainesville Hilton, Gainesville, Fla.

Fee: \$175; registration strictly limited to 125 participants

Credit: 40 hours; AMA Category 1; AAFP credit applied for
For Information: Dr. Bernice S. Scott, Coordinator, Continuing Education, University of Florida, 807 Seagle Bldg., Gainesville, Fla. 32601.

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

DOCTORS' DAY

At a time when taking "pot shots" at the medical profession seems to be a national pastime, we can still look forward with pride to the tradition of observing Doctors' Day. A Georgia medical auxiliary member, Mrs. C. B. Almond, in 1933 originated the idea and selected March 30 as the day to honor physicians with some "act of kindness, gift or tribute." The date is significant because Dr. Crawford Williamson Long of Jefferson, Georgia, first used ether successfully as an anesthetic in surgery on March 30, 1842. Although Dr. Long tried to persuade other doctors to use ether as an anesthetic, he did not make any effort to patent his discovery, and it was many years before he received recognition for his tremendous contribution to the art of medicine. In 1935 the Woman's Auxiliary to the Southern Medical Association adopted Mrs. Al-

mond's resolution to honor physicians on March 30, designating that day as Doctors' Day.

Auxiliaries have used newspapers, radio, television, the pulpit, and mayors' and Governor's offices to proclaim Doctors' Day throughout the land. In 1974, 80 percent of the North Carolina auxiliaries reported some form of Doctors' Day observance. At the Burke County Auxiliary dinner last year, six physicians who were practicing in 1935 or before were given special recognition, and a well researched history of medicine in Burke County since Revolutionary times was presented; the program was taped and presented to the Burke County Historical Society. Guilford County (High Point) published 400 copies of an illustrated book, *Out of the Black Bag, the Medical History of High Point*. New Hanover-Brunswick-Pender purchased a doll-model, Rescuer-Ann, for health clubs in two high schools to learn life-saving. Lee County contributed \$100 to the LPN scholarship of their local technical institute. The Northhampton County Auxiliary presented a two-volume *History of Medicine in North Carolina* to the hospital library in memory of the deceased physicians of that county.

Doctors' Day observances are both fun and worthwhile. At least once a year in North Carolina doctors are placed back on their well deserved pedestal.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Donald M. Hayes, professor and chairman of the Department of Community Medicine has been named associate dean for community health services at the medical school. His appointment is part of a new administrative plan established to facilitate coordination of all the medical school's community-related health service activities.

As associate dean, Dr. Hayes will be chairman of the newly created Community Health Services Council, established to integrate and coordinate elements of community-related programs, particularly those involved in such functions as the training of primary care physicians, consumer health education, ambulatory care and the continuing education of practicing physicians and allied health professionals. The council will have overall responsibility for the correlation of such activities as teaching, research and patient care services and evaluation of the various programs.

Membership on the council will include representatives of each academic department involved in

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community-related programs, including the recently established Department of Family Medicine, the new Department of Medical Social Science and Marital Health, the Department of Community Medicine and the allied health programs, as well as the traditional clinical departments.

Dr. Hayes, who will continue as chairman of community medicine, has also been given overall responsibility for a new section which incorporates the school's Division of Allied Health Sciences. The division has been reorganized to encourage coordination of the curriculum and service activities of community-related programs. Dr. James L. Pharris, associate professor, is the administrative director of the new section.

* * *

Recently appointed to full-time faculty were Dr. Meredith Gene Bond, instructor in comparative medicine; Dr. Mary Ruth McMahan, instructor in pathology; Dr. Alberto Trillo, assistant professor of pathology; and Clifton W. English and Thomas S. Guy III, instructors in the physician's assistant program.

Receiving appointments to part-time faculty were Dr. Owen W. Doyle, clinical assistant professor of radiology, and Dr. H. Ray Sturkie, clinical instructor in obstetrics and gynecology.

Thirteen students at the School of Medicine completed requirements for the Doctor of Medicine degree in January and have begun internship training.

* * *

Dr. Richard Janeway, dean, has been named to the North Carolina Board of Human Resources by Gov. James Holshouser.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, has been elected chairman of the Board of Censors, North Carolina District Branch of the American Psychiatric Association.

* * *

Dr. Richard W. St. Clair, associate professor of pathology, has been appointed an associate editor of *Artery*, a new international journal for rapid communication on arterial research.

* * *

Dr. Walter A. Ward, assistant professor of otolaryngology, has been appointed to the Education Committee of the American Society of Ophthalmologic and Otolaryngologic Allergy, and to the Continuing Education Committee of the Society of the University Otolaryngologists.

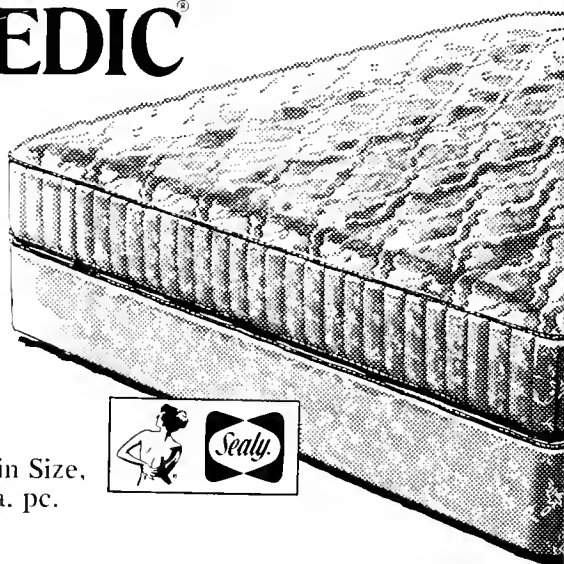
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News Notes from the—

**UNIVERSITY OF NORTH CAROLINA
DIVISION OF HEALTH AFFAIRS**

Dr. Gustavo Molina, a Latin American medical care expert and leader in the National Health Service in Chile under the Allende administration, delivered a series of lectures at UNC-Chapel Hill, Jan. 15-17. Now in exile from Chile after the Allende overthrow, he lives in Bogota, Colombia.

* * *

Alcoholism Awareness Week in North Carolina began its first annual scientific sessions at UNC-Chapel Hill, Jan. 22, as six distinguished researchers spoke on identifying and treating the alcoholic patient. Dr. John Ewing, a psychiatrist and director of the UNC Center for Alcohol Studies in Chapel Hill, spoke on "Tips on Identifying the Early Alcoholic." He warned that one of the most common causes of hypertension is rooted in overuse of alcohol.

* * *

The Ford Foundation has awarded a \$500,000 grant to help support the population program at UN-Chapel Hill. Dr. Thomas Hall, Carolina Population Center's acting director, said the grant would be used during the next three years in four areas: international program management, population policy development, population communications and overseas institution building.

* * *

Dr. Morris Schaefer, professor of health administration, School of Public Health, has written a new book on health administration, published by the World Health Organization (WHO). Entitled *Administration of Environmental Health Programs: A Systems View*, the book explains planning and management concepts needed by health program administrations.

* * *

Dr. Bernard G. Greenberg, dean of the School of Public Health and Kenan professor of biostatistics, has been elected to a second term on the Council of the Institute of Medicine of the National Academy of Sciences. He will represent the Institute on the Council for a full term until 1977, having filled an unexpired term of one year in 1974. Elected to the Institute in 1972, Greenberg was a member of the Committee on National Statistics of the National Academy of Sciences in 1972-1973 and has recently completed an assignment for the Coordinating Committee on Air Quality Studies of the Academy.

* * *

Dennis R. Barry has been named general director, effective immediately, of the North Carolina Memorial Hospital. He succeeds John M. Danielson,

who resigned in October 1974 to accept a position with the Capitol Area Health Consortium in Hartford, Connecticut.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Siegfried Heyden, professor of community health sciences, will receive the Hufeland Award for his work in preventive medicine. The award, which was named for a German physician who was a pioneer in preventive medicine, carries with it \$4,500 in cash, and will be presented to Heyden by the President of the Federal Republic of Germany, Walter Schaell, at ceremonies in Cologne, Germany, on April 23. Heyden also has been asked to deliver a lecture on health education.

The German Medical Association singled out Heyden for work he did over the past two years while on sabbatical leave in Switzerland. He was invited there to create a division of preventive medicine within the Department of Public Health in the St. Gall state of Switzerland.

* * *

Dr. Joseph Wadsworth, chairman of the Department of Ophthalmology, and Dr. A. C. Chandler, Jr., associate professor of ophthalmology have published two articles in the *American Journal of Ophthalmology* entitled "Conjunctivodacryocystostomy" and "Cataract Surgery—Review of 500 Consecutive Cases."

* * *

Doctors here have received a \$3.5 million grant to tackle the nation's No. 1 killer—coronary artery disease. The grant, the largest for the medical center over the past year, was awarded by the National Heart and Lung Institute and will support the work of 17 researchers over the next five years.

"Prolonging life and reducing disability—that's what we're interested in," said Dr. Andrew G. Wallace, head of the research team and chief of Duke's Cardiovascular Division. The associate director of the 17-man team is Dr. H. Newland Oldham, associate professor of surgery. Working with them will be: Dr. Robert W. Anderson, Dr. Robert J. Bache, Jr., Dr. John J. Gallagher, Dr. Joseph Greenfield, Jr., Dr. Donald B. Hackel, Dr. Robert H. Jones, Dr. Joseph A. Kisslo, Dr. Yihong Kong, Dr. James R. Margolis, Dr. Daniel B. Menzel, Dr. Charles R. Roe, Dr. Robert A. Rosati, Dr. Harold C. Strauss, Dr. Olaf T. Von Ramm and Dr. Galen S. Wagner.

Two of the researchers will try to curb these instant deaths by correcting the irregular heartbeats that precede them; one doctor will use drugs in his

effort and the other will try surgery. Two others will use sound waves to diagnose heart damage. "It's like radar," said Wallace. "Bursts of high frequency waves are bounced off the structures of the heart. You get a picture of the working heart and you can even visualize valves moving." One doctor will measure blood flow to the heart with radioactive chemicals that show up on X-rays to determine whether a coronary artery is clogging. Another researcher will try to surgically remove ballooning areas of the heart that contribute to heart failure. Yet another will create a computerized data bank that "will ultimately permit doctors to tell each new patient with coronary artery disease what medicine can and cannot accomplish for him," Wallace said. Two doctors will test whether the heart actually works better after surgery has been performed to by-pass a blocked section of coronary artery. Others will look for new ways to treat angina pectoris; try to reduce the damage that heart attacks do; test heart drugs on animals; and set up laboratories for continuing research on coronary artery disease.

* * *

The medical center will share in grants totaling \$2.8 million that have been awarded to the university by the Duke Endowment. In announcing the gifts, President Terry Sanford said that the Hospital and Child Care Section of the endowment appropriated \$1.5 million of the total for use in the medical center. The funds will be used for future needs of Duke Hospital.

* * *

Dr. Eugene E. Day, immunology and experimental surgery professor, was among four researchers who recently received grants from the National Multiple Sclerosis Society, pushing the society's 1974 appropriations for Multiple Sclerosis (MS) research closer to the \$3 million mark—its highest ever for research grants.

Day was awarded \$106,352 to help him and his associates continue studies of special characteristics of antibodies produced in animals with experimental allergic encephalitis (EAC), a laboratory-induced disease which resembles MS.

* * *

Dr. Susan Schiffman, assistant professor of medical psychology, has been appointed to the committee on sodium restricted diets of the National Academy of Sciences.

* * *

Dr. J. David Robertson, professor and chairman of the Department of Anatomy, has returned from five weeks in South America where he taught a course in electron microscopy in Santiago, Chile. He was also guest lecturer at the Second Latin American Electron Microscopy Congress in Ribeiro Preto, Brazil.

Robertson, who is currently working on an Italian edition of his book *Le Microscope et la Vie Art*

PREScribing INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

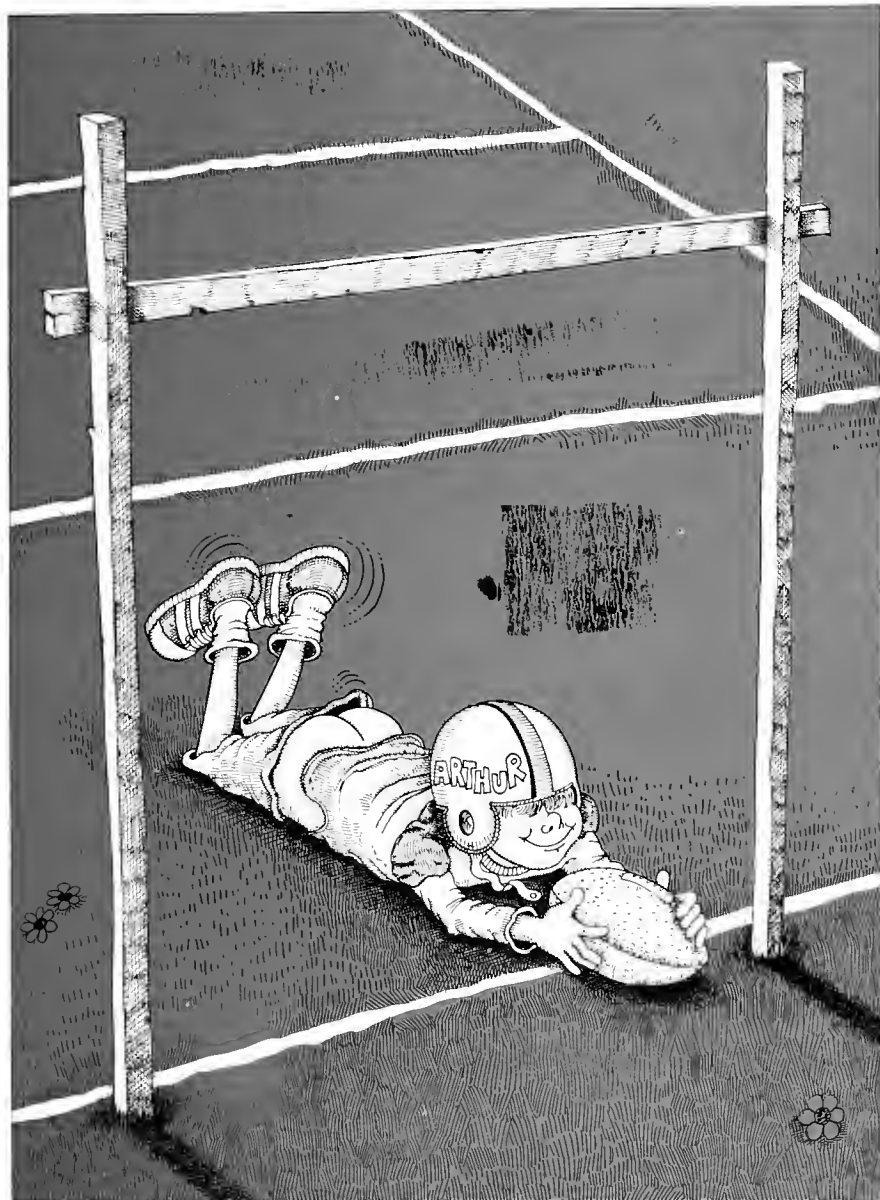
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitecups™ of 5 cc. in packages of 12.

VOL. 36, No. 3

ROERIG 
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies*. Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG 

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**Pinworms, roundworms controlled
with a single, non-staining dose of
ANTIMINTH®
(pyrantel pamoate)**

equivalent to 50 mg. pyrantel/ml.
ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

and several anatomy papers, has been named ad hoc member of the cell biology study section of the National Institutes of Health.

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

Appointed to Academy commissions and committees by the AAFP Board of Directors during its November 22-24, 1974 meeting, from North Carolina are:

Commission on Education: James G. Jones, M.D., Jacksonville, (1977).*

Commission on Public Health and Scientific Affairs: Robert Shackelford, M.D., Mt. Olive, (1975).*

Commission on Health Care Services: George T. Wolff, M.D., Chairman, Greensboro.

Commission on Legislation and Governmental Affairs: Amos N. Johnson, M.D., Garland, (1975).*

1975 Washington Consultants: Amos N. Johnson, M.D., Garland.

Committee on 1975 State Officers' Conference: Cranford O. Plyler, Jr., M.D., Thomasville.

Ad Hoc Committee on Quality Assurance for Ambulatory Care: George T. Wolff, M.D., Chairman, Greensboro.

AMA NATIONAL CONFERENCE ON DISABLED PHYSICIANS

The American Medical Association will sponsor a national conference on the "Disabled Physician," April 11-12, 1975, at the St. Francis Hotel in San Francisco. Alcoholism, drug dependence and mental disorders will be the major theme, focusing on treatment, rehabilitation and disciplinary action. Discussions on medical societies' relationships with state licensing bodies and legislative support mechanisms, and implementation of the AMA's "Disabled Physicians Act," will be held.

For further information, write to AMA Department of Mental Health, 535 N. Dearborn St., Chicago, Illinois 60610.

9TH AMA SOCIOECONOMIC CONGRESS

The 9th AMA Socioeconomic Congress will be held at the Regency Hyatt Hotel in Atlanta, Georgia, April 25-26. Sponsored by the AMA's Council on Medical Service and the Medical Association of Georgia, the one-and-a-half day meeting will focus on national health insurance.

This continuing medical education activity is acceptable on an hour-for-hour basis for category I credit for the AMA's Physician Recognition Award. The registration fee is \$50.00.

For further information, write to Karen A. Zupko, Division of Medical Practice, American Medical As-

* Terms to expire.

Rondomycin[®]

(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months. Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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**When the focus is on bronchitis due to
susceptible strains of *H. influenzae* and pneumococci***

Randomycin[®] 300 mg.
[methacycline HCl] Capsules

Delivers from the very first dose:

**Studies show that after the first dose serum levels rapidly rise above
minimum *in vitro* inhibitory concentrations**

*Since many strains are known to be resistant, routine sensitivity testing is recommended

MEDICAID HOSPITAL ADMISSION REVIEW PROGRAM (HARP) IMPLEMENTED ON A PHASE-IN BASIS BY THE NORTH CAROLINA MEDICAL PEER REVIEW FOUNDATION

Two recent governmental actions with respect to PSRO will have immediate impact in North Carolina. The first was passage of HEW Appropriations Bill for the fiscal year 1975 which budgeted \$37 million for the nationwide PSRO Program. This represents a substantial reduction in the original HEW request. The second item is the publishing of final rules in the November 29, 1974 Federal Register by the Secretary of HEW, mandating Hospital Admission Certification and Continued Stay Review on all Title XIX patients effective February 1, 1975. As for the Regulations of November 29 and their bearing on the PSRO—U/R relationship, perhaps the most significant comments appear in the Preamble to these Regulations in the Federal Register where it is stated:

"These Amendments provide that Utilization Review in Hospitals shall employ a system of Concurrent Review and Medical Care Evaluation Studies, compatible with that to be used in the PSRO Program. The PSRO Law provides for PSRO's to rely on the Review Activities of Hospital Utilization Review Committees which the PSRO determines are functioning effectively. *Effective operation of the Hospital Review System required under these Regulations shall facilitate the development and establishment of PSROs, and enable PSROs to concentrate their efforts on relatively smaller areas of questionable professional activity.*"

The major points of the final Regulations are as follows:

1. The initial D/HEW Notice of Proposed Utilization Review Rulemaking was published on January 9, 1974, in the Federal Register and the comment period was extended until March 1974 with over 4,700 comments received from interested organizations and individuals.

2. The Regulations of November 29, 1974, are in final form and became law on February 1, 1975.

3. These Regulations are divided into four sections that relate to Provider Requirements, Utilization Control Procedures, Utilization Review Procedures, and Financial Participation by the States in Utilization Activities.

4. *Hospitals and Nursing Home Facilities will be considered approved providers of inpatient care under Medicaid, only if they satisfy the new Utilization Control and Review Regulations.*

Each Hospital providing services under Medicaid must demonstrate to the State through a written plan that Inpatient Services are being reviewed according to the following requirements:

1. Admission Certification within one (1) working day.

2. Final determination of Certification within two (2) working days.

3. Utilize written Criteria in approval or disapproval of admissions.

4. Length of Stay Assignment for all approved admissions, not to exceed the fiftieth percentile.

5. Concurrent Review of Continued Stay prior to the expiration of Approved Length of Stay.

6. Provision of at least one MCE Study in progress at any given time, with one completed per year.

7. Actual operation of a U/R Committee, developing Admission Certification and Length of Stay Criteria, approve Length of Stay Extensions, and perform selected MCE Studies.

8. Collection of specific data items for all admissions.

Each Nursing Facility providing services under Medicaid must demonstrate to the State via a written plan that Patient Services are being reviewed according to the following requirements:

1. Operation of Utilization Review Committee.

2. Review of Plans of Care for all patients.

3. Assignment of Length of Stay and Continued Stay Review, after admission, at least every thirty (30) days for ninety (90) days, and ninety (90) days, thereafter for SNFs (or every six (6) months for ICFs).

4. Utilization of Written Criteria in the approval or disapproval of Continued Care, except that this requirement may be waived to allow for additional time for the development of Criteria.

5. Provision for at least one MCE Study to be in progress at any given time and for at least one MCE Study to be completed each year.

Under the Regulations, *Federal financial participation is available in accordance with each state's Title XIX rates, however, if a state does not meet the above requirements, all payments for Hospital, SNF, and ICF Services, after sixty (60) days, and payments for Mental Hospital Services after ninety (90) days, will be reduced by one-third.*

Therefore, the specific issues in the State of North Carolina, as a result of these new Medicaid Regulations were as follows:

1. The State Department of Human Resources was faced with the task of implementing a Program, as described above, themselves, with additional State Employee Personnel Staffing.

2. Negotiate with approximately 170 Hospitals in the State, and dealing with 170 plans by Hospitals to meet these requirements.

3. Deadline for implementation of such a plan was February 1, 1975.

On December 20, 1974, the North Carolina Medical Peer Review Foundation submitted a proposal to the State Department of Human Resources that

would satisfy the requirements specified in the Medicaid Utilization Review Regulations, therefore, assisting the State and the Hospitals in complying with the February 1, 1975 deadline for implementation. This proposal sets forth that the Foundation would perform a basic coordination role through the implementation and operation of a Hospital Admission Review Program (HARP), with three main objectives in mind:

1. Support the State and assure that the North Carolina Medicaid Program includes a uniform and coordinated quality and Utilization Review Program for all Inpatient Admissions.

2. Provide a well run and comprehensive Review Program so that all Hospitals and Long-Term Care Facilities would meet their provider requirements as set forth in the new Regulations.

3. Assure that as PSROs develop and reach the operational phase of "Conditional Status" that they assume their local roles as review bodies.

This would prevent the development of complex multiple review systems that would present a difficult and costly administrative tangle for the State, while assuring uniformity of data collection, appeals, and reporting procedures. All the while, the Foundation in all of its implementation activities would

seek and utilize the assistance and resources of already established PSROs.

The Foundation's phased development concept involves eight to ten (8-10) major Hospitals with a HARP Program in place, by February 1 with an additional twenty (20) Hospitals two months later, and all Hospitals with the Program on line, by June 1, 1975.

Mr. David Flaherty, Secretary, Department of Human Resources, in his deliberations, consulted with many interested organizations in addition to the North Carolina Medical Society, North Carolina Hospital Association, and other State Agencies involved, with the resultant decision being made on December 31, 1974. Mr. Flaherty notified M. Frank Sohmer, M.D., President, North Carolina Medical Peer Review Foundation, in a "Letter of Intent" of the decision to contract with the Foundation for the HARP Program effective January 1, 1975. The Foundation presently is recruiting necessary staff personnel and other start-up activities are under way.

For further information concerning implementation of HARP, contact: M. Frank Sohmer, M.D., President; Dan I. Mainer, Executive Director, at the Foundation offices located at 222 North Person Street, Post Office Box 27746, Raleigh, North Carolina, 27611; Telephone 919-828-7306.

Month in Washington

The 94th Congress, which has the largest group of Democratic freshmen representatives to have crossed the Potomac in a generation, has quickly proved that it has a will of its own and a flagrant disregard for the tradition of seniority. A successful "freshman revolt" within the House Democratic caucus has toppled a number of good-old-boys from important committee chairmanships and dealt a stinging blow to the half century old seniority system. A less dramatic, but just as significant, revolution, has quietly occurred in the Senate. Senator Edward Kennedy, (D-Mass.), after mustering a liberal coalition in his party's Steering Committee, handed out a beating to Democratic conservatives with respect to committee assignments. But what legislative inklings this tumultuous reorganization of the Congress holds for medicine is still far from clear.

Saddled with grave economic problems, President Ford stated unequivocally that his Administration will not introduce a national health insurance mea-

sure (NHI) in the first session of this Congress. Making it painfully clear in his State of the Union message that the Congress also has grave economic problems, the President said that he would veto any approved new spending programs other than those concerned with energy. His stand would seem to make it difficult indeed for Democratic liberals to get an NHI bill enacted this year, despite the enormous pressures from Labor. However, House Speaker Carl Albert (D-Okla.) in his party's formal reply to the State of the Union message, urged the President to reconsider vetoing NHI, saying it merits high priority. Other top members of the Democratic leadership in both houses have gone on record as favoring NHI this year, including Al Ullman (D-Ore.) who has replaced Wilbur Mills as Chairman of the House Ways and Means Committee.

During the organization of the 94th Congress, the House Ways and Means Committee was expanded from 25 to 37 members, largely through the addition

of liberals, and for the first time subcommittees were established—four. Under the “two-to-one-plus-one” formula governing party representation on committees, this means that Ways and Means now consists of 25 Democrats and 12 Republicans.

Chairman of the new Ways and Means subcommittee on health is Rep. Dan Rostenkowski (D-Ill.). Apparently determined to make a name for himself in the health field, the Chicago democrat has declared, “I see my role not as a proponent of an individual point of view, but rather as that of a consensus-builder—one who will try to resolve the differences that presently block the passage of this landmark program.” Rostenkowski said his 13-member panel will start work on health legislation immediately following Ways and Means’ deliberations on the President’s Emergency Energy and Tax message.

“Although regular meetings of my committee won’t begin until the early spring,” he said, “I hope that the other committee members will review the considerable materials that are now available on this subject in order that in the spring we can begin in earnest.

“At the present time, over \$100 billion is spent annually on the health care of the American people,

thus, any legislation that seeks to significantly alter both the financing and the delivery of that health care will have to be developed with an acute sensitivity of the many diverse problems involved. Equally as important in changing the present system of health care, we must also be concerned with the 4.4 million Americans who are employed in this, the nation’s third largest industry.”

Shortly after making this statement, Representative Rostenkowski announced the formation of an Advisory Panel of National Health Insurance, “a group from whom the subcommittee can draw expert information and advice for use in its work on national health insurance.” The subcommittee chairman’s statement continued: “The passage on national health insurance legislation is a must, but most important of all, it must be sound, workable legislation. The people who have agreed to serve on this Advisory Panel are recognized experts on various issues which the Subcommittee will have to resolve and should contribute much to our work.” The list of panel members, however, was not immediately released.

* * *

The parade of national health insurance bills has begun. Senator Kennedy and Representative James

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol).....	50m
NIACIN.....	50m
DIMENHYDRINATE (Dramamine).....	25m

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines, may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

Corman (D-Calif.), have introduced Labor's Health Security Act, essentially last year's Labor NHI measure calling for complete federal financing of health care for all at a cost of \$85 billion plus. Kennedy's action signified that he will again be the standard bearer of the Labor plan despite some coolness after the Senator last year supported a compromise plan drafted with Representative Wilbur Mills (D-Ark.). The American Hospital Association's "Ameriplan," calling for health care corporations centered on hospitals as the focus of the health care delivery system, dropped and sponsored anew by Chairman Al Ullman (D-Ore.) of House Ways and Means has been assigned the coveted *H.R. 1* legislative number.

It seems certain that a new version of the Senator Russell Long (D-La.) and Senator Abraham Ribicoff (D-Conn.) proposal for "catastrophic" NHI will also be introduced. There are some who believe that due to the faltering economy, the Long-Ribicoff proposal will draw more attention than it did in the last Congress. With unemployment rising, the "catastrophic" proposal could gain political popularity with its obvious advantages to hard-strapped families.

Not yet ready for introduction, the AMA's proposal may contain some changes from its Medicare bill of last year. The AMA House of Delegates at the Portland meeting last December gave the Board of Trustees a vote of confidence for its efforts to develop new approaches to national health insurance which maintain traditional AMA goals. It also adopted a Board report containing basic guidelines for national health insurance deliberations, including: minimum federal involvement in the administration of any national health insurance program; state jurisdiction for licensure of physicians and regulation of insurance; no Social Security tax financing and administration of any program; funding through federal revenues, state revenues and private funds, including employer-employee contributions, for private health insurance; comprehensive coverage for basic and catastrophic needs; and the maintenance of pluralism in health delivery. Additionally, AMA President Dr. Malcolm Todd has been quoted in the press as saying the objective of his organization's new national health insurance proposal will be to make it more flexible, while at the same time maintaining certain basic precepts.

* * *

Other changes have been made—with more still to come—in the structure of Congressional committees of interest to medicine, though none quite so spectacular as the re-vamping of the House Ways and Means Committee. The Senate health leadership lineup should be much the same this year. Chairman Russell Long of the Senate Finance Committee will be the dominant man in NHI, and Senator Herman Talmadge (D-Ga.), Chairman of Finance's Health Subcommittee, is slated to be heard from increas-

ingly. Senator Edward Kennedy again will be Chairman of the Health Subcommittee of Senate Labor and Public Welfare which is led by Sen. Harrison Williams (D-N.J.). Representative Paul Rogers (D-Fla.), is in line to continue as head of the powerful Health Subcommittee of the House Commerce Committee and to be even more influential in the 94th Congress due to the transfer of some health jurisdiction from Ways and Means. Rogers is sure to carve out a sizable chunk of any NHI program for his purview. Representative Harley O. Staggers (D-W. Va.), Chairman of the full Commerce Committee, was defeated in a bitter battle by Representative John E. Moss (D-Calif.), for the chair of the Special Subcommittee on Investigations. Moss has said he plans hearings on matters under the jurisdiction of the committee, including health.

* * *

Before the dust had settled from the skirmishing involved in the organization of the Congress, plans were being mapped for health legislative action. The House Commerce Subcommittee on Health is slated to take up quickly the two health bills vetoed late last year by President Ford—providing aid for Nurses Training and the \$1.8 billion measure authorizing community mental health centers, and neighborhood health centers. Sen. Edward Kennedy, chief of the Senate Health Subcommittee, has introduced both bills in a single package and defied another veto; not known is whether Congress will attempt to modify the measures to forestall a veto. The House and Senate Health Subcommittee also are slated to take up early the Health Manpower measure which collapsed in the final days of the last session. The Administration is still working on a new proposal. Kennedy is expected to make another pitch for his sweeping bill requiring compulsory federal service for young physicians and the licensing and re-licensing of physicians.

* * *

Medical liability is emerging as a hot topic on Capitol Hill. The Senate Health Subcommittee will hold mid-March hearings on a bill sponsored by Kennedy and Sen. Daniel Inouye, (D-Hawaii) embodying a no-fault approach plus arbitration. A controversial section requires physicians who wish to be included under the program to have their practice reviewed by Professional Standards Review Organizations and reside in states with licensure and relicensure laws. Representative Dan Rostenkowski, Chairman of the Health Subcommittee of Ways and Means, has submitted a bill calling for a federal study of the problem. Sen. Gaylord Nelson (D-Wis.) has a bill establishing a federally administered program of reinsurance to protect companies against catastrophic claims.

* * *

The Administration has asked Congress to bite the economy bullet on health programs this year. Count-

ing the mammoth Social Security Trust Fund outlays, the Health, Education and Welfare Department's total budget for the fiscal year 1976, starting in July, would be \$118.4 billion, some \$8.5 billion above spending this year. Most of the increase is due to scheduled hikes in Social Security retirement benefits.

Budget comparisons were more than usually complicated this year because of the risky assumptions that Congress will go along with President Ford's request for a budget "recession" (primarily from research and mental health funds) of \$1.2 billion for current HEW appropriations, including cutbacks of \$516 billion in health programs. As a result, though the 1976 budget for health programs in the so-called "controllable" area was described as "hold-the-line," the projected non-Medicare-Medicaid health outlays of \$4.5 billion would actually be \$500 million less than Congress initially appropriated for the present fiscal year.

The most controversial aspect of the HEW budget is the Ford Administration's proposal for economies

in the "uncontrollable" trust fund field, recommendations that will require Congressional legislation. President Ford is asking Congress to limit the slated eight to nine percent increase in Social Security retirement benefits to five percent. He is seeking to curb Medicare spending by initiating higher cost-sharing provision for parts A and B. In addition, the Administration wants to reduce, from 50 percent to 40 percent, federal matching grants to the wealthier states. Few people in the Administration are sanguine about the possibilities of a liberal Congress going along with the proposed economies in the sensitive health-welfare area. "Accomplishing this slowdown in the growth of the HEW budget will not be easy," conceded HEW Secretary Caspar Weinberger.

"Even with all of the proposals put forward by the President to reduce or slow down the growth of various government programs, the 1975 and 1976 projected deficits still will total more than \$86 billion, unprecedented deficits for peacetime. But, if the President's budget proposals are not adopted, the two-year deficit could reach \$107 billion . . . which could be ruinous," Weinberger said.



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Book Reviews

General Ophthalmology. 7th edition. By Daniel Vaughan, M.D., and Taylor Asbury, M.D. 334 pages. Price, \$9.50. Los Altos, California: Lange Medical Publications, 1974.

It is not without good reason that this textbook of general ophthalmology has weathered the test of time since 1956, the year of its birth. It was an excellent paperback for use by medical students and first-year ophthalmology residents when I was a medical student, and the same remains true today, eighteen years later. The book is in its seventh edition and the changes have kept it current and relevant.

Other general textbooks of ophthalmology provide superior sections covering the anatomy and physiology of the eye, *but*, Vaughan's and Asbury's textbook ranks among the best, covering clinical ophthalmology in general.

The book is one to be read and reread, and to be carried either on the wards or in the physician's "black bag" and then thrown out and replaced by the eighth edition when that is published. With the rapid expansion of clinical knowledge, a paper-bound textbook of general ophthalmology seems to be ideal. The primary assets of this book are that it is current and the references are up to date.

The material is readable and easily assimilated. Diseases of the eye are covered in a systematic, comprehensive and authoritative fashion. Most medical students I know have a copy of one of the editions of this book, and rightly so. I unreservedly recommend it to all who might need a textbook covering all aspects of clinical ophthalmology.

JOHN A. STANLEY, M.D.

Review of Medical Microbiology. 11th edition. By E. Jawetz, J. L. Melnick and E. Adelberg. 528 pages. Price, \$8.50. Cleveland, Ohio: CRC Press, Chemical Rubber Co., 1974.

The 11th edition of this familiar manual is nearly identical to its previous edition. The authors have added ten pages primarily in the immunology chapters, understandable in light of recent developments in the field. The photographs, diagrams and figures are a credit to this publication.

Regrettably, more than one-third of the manual is still devoted to virology and since it is widely used by medical students, more emphasis should be placed on correlating the clinical aspects of infectious disease with laboratory findings. Infections caused by *Bacteroides* and other anaerobic organisms, besides the classic clostridial infections, are barely discussed, especially unfortunate since these anaerobes play an important role in a variety of infectious processes.

Molecular aspects of immunology and virology would be more appropriate in advanced publications suitable for those who are seeking a career in research.

Its deficiencies notwithstanding, this manual continues to provide a good review of the basic aspects of medical microbiology, and it is a valuable adjunct to more comprehensive publications.

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Program

NORTH CAROLINA MEDICAL SOCIETY

May 1-4, 1975

PINEHURST HOTEL
Pinehurst, North Carolina

Thursday, May 1, 1975

- 9:00 a.m.-5:00 p.m. — AUDIO-VISUAL PROGRAM—(HMS Bounty)
10:30 a.m.—Section on Urology meeting — (Pine Room)
12:30 p.m.—Section of Ophthalmology Luncheon—(Crystal Room)
2:00 p.m.—Section on Ophthalmology Meeting—(Pine Room)
2:00 p.m.—HOUSE OF DELEGATES — OPENING SESSION — (Cardinal Ballroom)
6:30 p.m.—Section on Urology — Social Hour (HMS Bounty)

Friday, May 2, 1975

- 7:30 a.m.—MEDICINE AND RELIGION BREAKFAST (In Remembrance) —(Crystal Room)
9:00 a.m.—FIRST GENERAL SESSION — —(Cardinal Ballroom)
9:00 a.m.-5:00 p.m. — AUDIO-VISUAL PROGRAM—(HMS Bounty)
2:00 p.m.—REFERENCE COMMITTEE meetings: I—Cardinal Ballroom
II—Pine Room
2:00 p.m.—Section on Pediatrics Meeting — (Crystal Room)
2:00 p.m.-3:30 p.m.—Section on Public Health & Education — (Holly Inn — TV Lounge)
2:00 p.m.—Section on Otolaryngology — (Ballroom—Holly Inn)
2:30-4:00 p.m.—Section on Family Physicians — (Parlor #129)
5:00 p.m.—NCSIM — Business Meeting — (Augusta Cottage)
5:30 p.m.—NCSIM — Social Hour — (Augusta Cottage)
5:30 p.m.—RECEPTION — Univ. of Virginia Medical Alumni—(London Grill)
5:30 p.m.—SOCIAL HOUR — Bowman Gray Medical Alumni—(Pine Room)

- 6:00 p.m.—EXHIBITORS' PARTY — (Land Sales Office)
6:00 p.m.—SOCIAL HOUR — UNC Medical Alumni—(Ballroom—Holly Inn)
6:00 p.m.—SOCIAL HOUR—Medical College of Virginia—(Parlor #129)
6:30 p.m.—COCKTAILS—Duke Medical Alumni —(Poolside)
7:00 p.m.—MEDPAC DINNER—(Cardinal Ballroom)
(Everyone invited to attend)
7:30 p.m.—DINNER—Duke Medical Alumni—(Crystal Room)
7:30 p.m.—North Carolina Academy of Family Physicians—(Pine Room)
Board of Directors Meeting

Saturday, May 3, 1975

- 7:00 a.m.—MEDPAC Board of Directors — Breakfast Meeting—(Parlor #129)
7:30 a.m.-11:00 a.m.—Breakfast & Scientific Session—Section on Neurological Surgery—(London Grill)
8:45 a.m.-12:15 p.m.—Section on Neurology & Psychiatry Meeting—(Pine Room)
9:00 a.m.—SECOND GENERAL SESSION — (Cardinal Ballroom)
10:00 a.m.-4:00 p.m.—Section on Pathology Meeting—(TV Lounge—Holly Inn)
12:30 p.m.—LUNCHEON—Section on Surgery—(Crystal Room)
1:00 p.m.—PICNIC—Section on Dermatology—(Poolside)
1:30 p.m.—Section on Orthopaedics — Business Meeting—(Pine Room)
1:30 p.m.-5:30 p.m.—Section on Radiology — (HMS Bounty)
2:00 p.m.—HOUSE OF DELEGATES — SECOND SESSION — (Cardinal Ballroom)
3:00 p.m.—Section on Dermatology Meeting — (Crystal Room)
6:30 p.m.—PRESIDENT'S RECEPTION—(Land Sales Office)
7:30 p.m.—PRESIDENT'S DINNER — (Dining Room)
9:00 p.m.—PRESIDENT'S BALL — (Cardinal Ballroom)

Sunday, May 4, 1975

- 8:00 a.m.—**BREAKFAST & MEETING** — Auxiliary Board of Directors—(Crystal Room)
9:00 a.m.—**THIRD GENERAL SESSION** — (Cardinal Ballroom)

GENERAL SESSIONS

FIRST GENERAL SESSION

Friday, May 2, 1975 Cardinal Ballroom
9:00 a.m.-12:30 p.m.

Convene Session

Presiding: Frank R. Reynolds, M.D., President
Wilmington

Invocation:

Medical Session

Department of Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina

9:00 a.m.—**OPENING REMARKS**

Christopher C. Fordham, III, M.D.,
Dean, University of North Carolina, School of Medicine, Chapel Hill

9:15 a.m.—**INTRODUCTION**

John T. Sessions, Jr., M.D., Governor, American College of Physicians, North Carolina Chapter

9:20 a.m.—**REHABILITATION AFTER MYOCARDIAL INFARCTION**

Daniel T. Young, M.D., Professor of Medicine

9:30 a.m.—**ADVANCES IN GASTROINTESTINAL ENDOSCOPY**

John T. Sessions, Jr., M.D., Professor of Medicine; Chief, Division of Gastroenterology

10:00 a.m.—**ROCKY MOUNTAIN SPOTTED FEVER**

Janet J. Fischer, M.D., Professor of Medicine and Associate Professor of Bacteriology

10:20 a.m.—**BREAK**

10:35 a.m.—**CHRONIC DIALYSIS AND RENAL TRANSPLANTATION IN NORTH CAROLINA IN 1975**

William B. Blythe, M.D., Professor of Medicine and Chief, Division of Nephrology

10:55 a.m.—**LEUKEMIA AND LYMPHOMA**

Jeffress G. Palmer, M.D., Professor of Medicine

11:15 a.m.—**THE SPECTRUM OF ALCOHOLIC LIVER DISEASE**

Eugene M. Bazymski, M.D., Associate Professor of Medicine

11:35 a.m.—**THE MANAGEMENT OF RHEUMATOID ARTHRITIS**

Norton M. Hadler, M.D., Assistant Professor of Medicine and Bacteriology

11:55 a.m.—**ADJOURN**
ANNOUNCEMENTS

SECOND GENERAL SESSION

Saturday, May 3, 1975 Cardinal Ballroom
9:00 a.m.-12:30 p.m.

Convene Session

Presiding: Jack Hughes, M.D., Durham, First Vice-President

Surgical Session

Department of Surgery, Duke University Medical Center, Durham

MODERATOR: David C. Sabiston, Jr., M.D., James B. Duke Professor & Chairman of Department of Surgery, Duke University Medical Center, Durham

9:00 a.m.—**OPENING REMARKS:** Ewald W. Busse, M.D., Director, Medical Education, Duke University

9:10 a.m.—**MANAGEMENT OF CARDIOGENIC SHOCK**

Robert W. Anderson, M.D.

9:20 a.m.—**PARIETAL CELL VAGOTOMY FOR PEPTIC ULCER**

R. Scott Jones, M.D.

9:30 a.m.—**SURGICAL MANAGEMENT OF SEVERE EPISTAXIS**

Patrick A. Kenan, M.D.

9:40 a.m.—**CHEMOTHERAPY FOR MALIGNANT GLIOMAS OF THE BRAIN**

M. Stephen Mahaley, M.D.

9:50 a.m.—**INDICATIONS AND RESULTS IN TOTAL REPLACEMENT OF THE HIP**

Donald E. McCollum, M.D.

10:00 a.m.—**CURRENT STATUS OF SURGERY FOR MYOCARDIAL ISCHEMIA**

H. Newland Oldham, Jr., M.D.

10:10 a.m.—**DISCUSSION**

10:30 a.m.—**BREAK**

10:40 a.m.—**SURGICAL MANAGEMENT OF REGIONAL ENTERITIS**

William P. J. Peete, M.D.

10:50 a.m.—**COMPOSITE FLAP TRANSFER UTILIZING MICROVASCULAR TECHNIQUES**

Donald Serafin, M.D.

11:00 a.m.—**PRESENT STATUS OF RENAL TRANSPLANTATION**

Hilliard F. Seigler, M.D.

11:10 a.m.—DIAGNOSTIC METHODS IN PEDIATRIC UROLOGY
John L. Weinerth, M.D.

11:30 a.m.—USE OF ADJUVANT THERAPY IN PATIENTS WITH EARLY BREAST CANCER
Samuel A. Wells, Jr., M.D.

11:30 a.m.—ROLE OF MONITORING IN MODERN ANESTHESIA
David A. Davis, M.D.

11:40 a.m.—DISCUSSION

12:00 Noon—ANNUAL ADDRESS OF THE PRESIDENT
Frank R. Reynolds, M.D., President, Wilmington

THIRD GENERAL SESSION

Sunday, May 4, 1975 Cardinal Ballroom
9:00 a.m.-12:30 p.m.

Convene Session

Presiding: M. Frank Sohmer, Jr., M.D., Winston-Salem, Second Vice-President

SOCIO-ECONOMIC SESSION

MODERATOR:

9:00 a.m.—CONJOINT SESSION

North Carolina Medical Society and
North Carolina Division of Health Services

Jacob Koomen, M.D., State Health Director, Raleigh

9:30 a.m.—EMERGENCY ROOM CARE IN NORTH CAROLINA — report on the support program by private Foundations

Mr. William F. Henderson, Raleigh, Director of the Program on Access to Health Care

10:00 a.m.—TIME MANAGEMENT FOR PHYSICIANS

George S. Conomikes, CONOMIKES ASSOCIATES, INC., Marina Del Rey, California

Q & A period

11:00 a.m.—Address: Malcolm C. Todd, M.D., President, AMERICAN MEDICAL ASSOCIATION, Long Beach, California

11:45 a.m.—Address: James E. Davis, M.D., President, NORTH CAROLINA MEDICAL SOCIETY, Durham

12:30 p.m.—Awarding of Prizes

Josephine E. Newell, M.D., Chairman, ANNUAL CONVENTION COMMISSION

ADJOURN SINE DIE

POSTGRADUATE AUDIO-VISUAL PROGRAM

G. Patrick Henderson, Jr., M.D., Chairman, Pinehurst

Morning Session

Thursday, May 1, 1975—9:00 a.m.-12:00 Noon—
HMS Bounty Room

MODERATOR: Jack C. Evans, M.D., Lexington

9:00 a.m.—MEDICAL FACTS FOR PILOTS

This film is directed particularly to beginning pilots and it provides a look at some of the fundamental, physical, physiological and psychological limitations in flight. Alerts pilots to such aeromedical factors as disorientation, the effect of alcohol, oxygen requirements and pilot vision.

9:30 a.m.—CASE IN POINT

This film aims at creating a keen sense of appreciation for the sensitive role of the medical assistant, in protecting herself and her doctor-employer from malpractice suits.

10:00 a.m.—ANAEROBIC INFECTIONS

Discusses and demonstrates the proper techniques of diagnosis, bacterial identification, and treatment of anaerobic bacterial organisms.

10:25 a.m.—HUNTINGTON'S DISEASE

This film shows several representative cases with special attention directed to the less commonly recognized rigid form of this disease.

10:40 a.m.—ILEAL CONDUIT URINARY DIVERSION

The details of ileal conduit urinary diversion, accomplished in this case as a therapeutic effort in management of neurogenic disease, are elaborated with emphasis on technique of the ileal re-anastomosis, ureteroileal anastomoses, and fashioning of the ileal stoma.

11:00 a.m.—TESTICULAR TORSION

This film shows the fetal development of the testicle. Also comparison of normal and abnormal testis and presents abnormal variations all exhibiting testicular torsion.

11:20 a.m.—I LOVE YOU FRANK

This film depicts what can go wrong in a medical emergency. Based on a true story, the film dramatizes some inadequacies of emergency-medical service systems in communities across the country.

Afternoon Session

Thursday, May 1, 1975—2:00 p.m.-5:00 p.m.—
HMS Bounty Room

MODERATOR: Paul McB. Abernethy, M.D., Burlington

2:00 p.m.—CONGESTIVE HEART FAILURE

This film depicts the signs and symptoms of congestive heart failure, and describes the clinical treatment and long-term program of treatment.

2:25 p.m.—THE ROLE OF THE ENDOMETRIUM IN CONCEPTION AND MENSTRUATION

This film presents the discussion on the physiology of the menstrual cycle with and without conception intervening. Endometrial changes both in the fertile and infertile cycle are discussed and illustrated.

3:00 p.m.—HYPOTONIC DUODENOGRAPHY

This film depicts how hypotonic duodenography is a radiological method for demonstrating the duodenum, distended and quiet.

3:30 p.m.—ALDOSTERONE AND ESSENTIAL HYPERTENSION

This film discusses aldosterone physiology in health and disease. Compares aldosterone metabolism in normals and hypertensives.

4:00 p.m.—CLINICAL APPLICATIONS OF GASTROSCOPY INTRAGASTRIC PHOTOGRAPHY AND GASTRIC BIOPSY

This film demonstrates the indication for gastroscopy, also demonstrates two fiber gastroscopes. Cases are presented with good views of intragastric conditions. Attempt is made to differentiate gastric ulcer from gastric carcinoma.

4:25 p.m.—LUBRICATION IN HEALTHY AND ARTHRITIC JOINTS

This film illustrates how joints are lubricated, and explains the roles of articular cartilage and synovial fluid. Also demonstrates what happens when Nature fails to lubricate joints, as in arthritis and includes explanations between inflammatory and degenerative arthritis, and various types of therapy both medical and surgical.

4:45 p.m.—TREATMENT OF SIMPLE HEAD INJURIES

This film is directed to the meticulous care necessary in the exami-

nation and treatment of the simple head injury.

Morning Session

Friday, May 2, 1975—9:00 a.m.-12:00 Noon—
HMS Bounty Room

MODERATOR: J. Benjamin Warren, M.D., New Bern

9:00 a.m.—WHAT CAN YOU DO?

This is a new concept in community health care. By staffing community clinics with kindred, sympathetic medicos, there is a responsive rapport often leading to more successful diagnosis.

9:40 a.m.—MANAGEMENT OF BURNS IN ER DEPARTMENT

The principles and priorities of resuscitative care, as practiced in the Emergency Department for burns of the face, neck, shoulder girdle, upper extremities and perineum, are detailed in the care of an 11-month-old male infant who has sustained a burn involving 28% of total body surface.

10:00 a.m.—NEEDLE ASPIRATION OF BREAST CYSTS

The rationale for needle aspiration is explained and the technique demonstrated.

10:15 a.m.—MANAGEMENT OF UPPER AIRWAY OBSTRUCTION

This film outlines the indications and the steps in management of upper airway obstruction from various causes.

10:30 a.m.—RENAL VASCULAR HYPERTENSION

This film includes diagnosis, treatment, and post-operative course of a 47-year-old male with renovascular hypertension.

10:45 a.m.—COMPLETE OFFICE GYNECOLOGICAL EXAMINATION

This film conveys the conception of an adequate office gynecological examination. Primary emphasis is placed on the importance of considering the entire woman, with particular emphasis on the complete gynecological examination.

11:05 a.m.—EMERGENCY ROOM TRAUMA

This film is intended to show the intensive initial evaluation and care of the injured patient, including communications, triage, resuscitation and priorities for management, as well as initial diagnostic, and therapeutic measures.

11:35 a.m.—CARDIAC ARREST

This film reveals a review of the causes and pathophysiology of cardiac arrest and of the techniques of resuscitation and their results.

Afternoon Session

Friday, May 2, 1975—2:00 p.m.-5:00 p.m.—HMS
Bounty Room

MODERATOR: Thornton R. Cleek, M.D., Asheville

2:00 p.m.—THE ROLE OF THE PRACTICING
PHYSICIAN IN THE INVESTI-
GATION OF SUDDEN, UNUSU-
AL, UNNATURAL OR SUSPI-
CIOUS DEATH

Slides from the office of Dr. Page
Hudson, Chief, North Carolina
Medical Examiner

3:00 p.m.—NATURAL DEATH AT THE
WHEEL

Slides from the Medical Examiner's
office regarding causes, and fac-
tors in natural death while operat-
ing a motor vehicle.

3:15 p.m.—DISORIENTATION

This aeromedical film alerts the
pilot to inflight situations that are
potentially disorienting by de-
scribing how this physiological
phenomenon influences and often
distorts flying judgments.

3:40 p.m.—HYPOXIA

This film shows the simple precau-
tionary steps pilots should take to
avert the threat of hypoxia, since
the body has no built-in alarm sys-
tem, and its subtle and insidious
symptoms of hypoxia.

4:00 p.m.—ENDOSCOPIC TECHNIQUES IN
GYNECOLOGY

Culdoscopy and laparoscopy are
most useful procedures in the di-
agnosis and treatment of gyneco-
logical conditions. Their applica-
tions are differentiated and dem-
onstrated in detail in this film.

4:30 p.m.—DIABETES IN OLDER PATIENTS

This film explains and demonstrates,
with actual patients, the diagnosis
and the difficulty in management
of older patients with diabetes.

SPECIALTY SECTIONS

SECTION ON UROLOGY

Thursday, May 1, 1975

10:30 am.-12 Noon (Pine Room)

CHAIRMAN: P. G. Fox, Jr., M.D., Raleigh

SECTION ON OPHTHALMOLOGY

Thursday, May 1, 1975

LUNCHEON & BUSINESS MEETING

12:30 p.m. (Crystal Room)

CHAIRMAN: E. R. Wilkerson, Jr., M.D., Charlotte

VICE-CHAIRMAN: Harold N. Jacklin, M.D.,
Greensboro

SECRETARY: H. Maxwell Morrison, Jr., M.D.,
Pinehurst

Chairman—Nominating Committee: J. David Strat-
ton, M.D., Charlotte

Chairman—Eye Care Committee: Ernest W. Larkin,
Jr., M.D., Washington

SCIENTIFIC MEETING

1:55 p.m. (Pine Room)

CALL TO ORDER: Harold N. Jacklin, M.D., Vice-
Chairman and Program Chairman

2:00 p.m.—ORBITAL MUCORMYCOSIS

Larry Sippe, M.D., Charlotte

2:10 p.m.—VITREOUS HEMORRHAGE FOL-
LOWING INTRACRANIAL
BLEEDING

Maurice B. Landers, III, M.D. and
Harold Ellis Shaw, M.D., Duke
University Medical Center, Dur-
ham

2:20 p.m. AN IMPROVED HEADREST FOR
EXTRAOCULAR MUSCLE SUR-
GERY

E. R. Wilkerson, Jr., M.D., Charlotte

2:30 p.m.—REMOVAL OF LENS FRAG-
MENTS WITH THE VITREOUS
INFUSION SUCTION CUTTER

Harold N. Jacklin, M.D., Greens-
boro

2:40 p.m.—MOBILE EYE CARE UNIT IN
NORTH CAROLINA

Marshall S. Redding, M.D., Eliza-
beth City

2:50 p.m. to 3:05 p.m.—COFFEE BREAK and
Inspection of Mobile Eye Care Unit

3:05 p.m.—SEMINAR: New automation instru-
ments in ophthalmology: Auto Re-
fractors, Auto Lensometers, To-
nometer, etc.

Chairman: E. R. Wilkerson, Jr.,
M.D.

Guest Moderator: Mr. Thomas
Sloan, M.S., Southern Optical,
Greensboro

Panel Members:

3:10 p.m.—E. E. Moore, M. D.,
Asheville

3:20 p.m.—L. B. Holt, M.D., Win-
ston-Salem

3:30 p.m.—W. R. Harris, M.D.,
Hickory

3:40 p.m.—R. F. Barbe, M.D.,
Tarboro

3:50 pm.—S. M. White, M.D.,
Greenville

4:00 p.m.—Discussion and Questions

4:15 p.m.—DEMONSTRATIONS OF AUTO
REFRACTORS

Acuity Systems
Coherent Radiation
Bausch & Lomb

5:00 p.m.—ADJOURNMENT

SECTION ON PUBLIC HEALTH & EDUCATION

Friday, May 2, 1975

2:00 p.m.-3:30 p.m. TV Lounge, Holly Inn
CHAIRMAN: W. Burns Jones, Jr., M.D., Chapel
Hill

"GREEN-TOBACCO SICKNESS" in North Caro-
lina

Stephen H. Gehlback, M.D., Medical Consultant,
Epidemiology Section, North Carolina Division
of Health Services

PESTICIDES POISONING IN NORTH CARO-
LINA: a status report

Mr. Wilton A. Williams, Pesticides Epidemiologist,
Epidemiology Section, North Carolina Division
of Health Services.

Election of Officers and Delegate for 1976

SECTION ON PEDIATRICS

Friday, May 2, 1975

2:00 p.m.-4:30 p.m. Crystal Room
CHAIRMAN: Eugene B. Cannon, M.D., Asheboro

PROGRAM CHAIRMAN: Jimmy L. Simon, M.D.,
Winston-Salem

OFFICE SCREENING PROCEDURES FOR
CHILDREN

2:00 p.m.-2:20 p.m.—REVIEW OF THE AMER-
ICAN ACADEMY OF PEDI-
ATRICS SCREENING RECOM-
MENDATIONS

Michael R. Lawless, M.D., Dept. of
Pediatrics, Bowman Gray School
of Medicine, Winston-Salem

2:40 p.m.-3:00 p.m.—VISUAL SCREENING
Charles N. Swisher, M.D., Dept of
Pediatrics, UNC School of Medi-
cine, Chapel Hill

2:40 p.m.-3:00 p.m.—VISUAL SCREENING
M. Madison Slusher, M.D., Dept. of
Ophthalmology, Bowman Gray
School of Medicine, Winston-
Salem

3:00 p.m.-3:20 p.m.—HEARING SCREENING
Vern Kunze, Ph.D., Director, Center
for Speech and Hearing Dis-

orders, Duke University School of
Medicine, Durham

3:20 p.m.-3:40 p.m.—SCREENING FOR URI-
NARY TRACT DISEASE

William B. Lorentz, Jr., M.D., De-
partment of Pediatrics, Bowman
Gray School of Medicine, Win-
ston-Salem

3:40 p.m.-4:00 p.m. — TUBERCULOSIS
SCREENING

Laura E. Gutman, M.D., Dept.
of Pediatrics, Duke University
School of Medicine, Durham

4:00 p.m.-4:30 p.m.—ROUND TABLE DISCUS-
SION AND QUESTIONS FROM
THE AUDIENCE:

Drs. Lawless, Swisher, Slusher,
Kunze, Lorentz and Gutman

SECTION ON OTOLARYNGOLOGY

Friday, May 2, 1975

2:00 p.m. Ballroom, Holly Inn

CHAIRMAN: Nathaniel L. Sparrow, M.D., Raleigh

SECTION ON FAMILY PHYSICIANS

Friday, May 2, 1975

2:30 p.m.-4:00 p.m. Parlor #129—East Wing

CHAIRMAN: C. O. Plyler, Jr., M.D., Thomasville

MODERATOR: Charles H. Duckett, M.D.

DEVELOPMENT OF THE FAMILY PRACTICE
PROGRAM AT BOWMAN GRAY SCHOOL
OF MEDICINE

Business Session: Election of Officers, Delegate and
Alternate Delegate for 1975-76

* * *

7:30 p.m.—BOARD OF DIRECTORS Meeting—
(Pine Room)
(North Carolina Academy of Family
Physicians)

SECTION ON INTERNAL MEDICINE

Friday, May 2, 1975

5:00 p.m. Augusta Cottage

CHAIRMAN: W. W. Fore, M.D., Greenville

Business Meeting only

Election of Officers, Delegate and Alternate Dele-
gate for 1975-76

(Scientific portion of Section on Internal Medicine
is a part of the First General Session)

5:30 p.m.—SOCIAL HOUR Augusta Cottage
North Carolina Society of Internal
Medicine

SECTION ON NEUROLOGICAL SURGERY

Saturday, May 3, 1975

7:30 a.m.-11:00 a.m.

London Grill

CHAIRMAN: Ira M. Hardy, II, M.D., Greenville
BREAKFAST AND SCIENTIFIC SESSION

7:30 a.m.—Breakfast

8:00 a.m.-11:00 a.m.—Scientific Session

Election of Officers, Delegate and Alternate Delegate
for 1975-76

SECTION ON NEUROLOGY & PSYCHIATRY

Saturday, May 3, 1975

8:45 a.m.-12:15 p.m.

Pine Room

CHAIRMAN: Marianne S. Breslin, M.D., Durham
BIO-FEEDBACK TRAINING AS AN ADJUNCT
TO PSYCHIATRIC TREATMENT

Redford E. Williams, Jr., M.D., Assistant Profes-
sor of Medicine and Psychiatry, Duke University
Medical Center, Durham

A REVIEW OF THE NEUROANATOMICAL
AND NEUROCHEMICAL BASIS OF EMO-
TION

J. Gordon Burch, M.D., Assistant Professor of
Neurology, Duke University Medical Center,
Durham

RECENT DEVELOPMENTS OF PSYCHOPHAR-
MACOLOGY

Arthur Prange, Jr., M.D., Professor of Psychiatry,
University of North Carolina, Chapel Hill

SECTION ON PATHOLOGY

Saturday, May 3, 1975

10:00 a.m.-4:00 p.m.

TV Lounge, Holly Inn

CHAIRMAN: W. H. Davidson, M.D., Laurinburg

SECTION ON SURGERY

Saturday, May 3, 1975

12:30 p.m.

Crystal Room

CHAIRMAN: Robert W. Youngblood, M.D., Wil-
son

LUNCHEON MEETING—(wives welcomed)

Election of Officers

Announcements

Items of Surgical Interest

Scientific portion of Section on Surgery is a part of
the Second General Session

ADJOURN

SECTION ON ORTHOPAEDICS

Saturday, May 3, 1975

1:30 p.m.

Pine Room

CHAIRMAN: James R. Dineen, M.D., Wilmington

Panel

1:30 p.m.—DISABILITY EVALUATION

(A selected panel of "experts" will
have had the opportunity to re-
view three test cases for disability
evaluation prior to arrival at this
meeting. The attending orthopae-
dists will be provided with these
cases, as handouts, and will have
an opportunity to debate with the
panel any issues that need that
type of discussion or clarifica-
tion.)

2:30 p.m.—PSRO and UR EXPERIENCE

It is hoped that the attendance at
this meeting will be representative
of many areas of our State, in or-
der that experiences to date may
be shared, and everyone may
profit in order to make this
"THING" work.

3:30 p.m.—MALPRACTICE INSURANCE

"Where are we going—staying?"

SECTION ON RADIOLOGY

Saturday, May 3, 1975

1:30 p.m.-5:30 p.m.

HMS Bounty

CHAIRMAN: Julius A. Green, Jr., M.D., Raleigh

SECTION ON DERMATOLOGY

Saturday, May 3, 1975

3:00 p.m.

Crystal Room

CHAIRMAN: Charles M. Howell, Jr., M.D., Win-
ston-Salem

SECRETARY: Elizabeth Kanof, M.D., Raleigh

SYMPOSIUM ON CUTANEOUS SURGERY

Participants: George L. Popkin, M.D.

Professor of Clinical Dermatology
New York University
New York

Gloria F. Graham, M.D., Wilson
Assistant Clinical Professor of Derma-
tology
University of North Carolina, Chapel
Hill

George W. Crane, Jr., M.D., Durham
Assistant Clinical Professor of Derma-
tology
University of North Carolina, Chapel
Hill

ELECTION of Officers, Delegate and Alternate
Delegate for 1975-76

OFFICIAL CALL HOUSE OF DELEGATES

pursuant to the Bylaws, Chapter IV, Section 1:

HOUSE OF DELEGATES Meetings scheduled

**Notice to: Delegates, Alternate Delegates, Officials
of the North Carolina Medical Society, and Presidents
and Secretaries of county medical societies.**

Sessions of the HOUSE OF DELEGATES will convene in
the Cardinal Ballroom, The Carolina, Pinehurst, North
Carolina, at the following times:

Thursday, May 1, 1975—2:00 p.m.—Opening Session

Saturday, May 3, 1975—2:00 p.m.—Second Session

A member of the CREDENTIALS COMMITTEE will be present at
the Desk in the Registration Office, Thursday, May 1, 1975, from
8:30 a.m. to 12:30 p.m. to certify Delegates. Delegates are urged
to bring their Credential Cards for presentation at the Registration
Office. Delegate Badges must be worn to be seated in the HOUSE
OF DELEGATES.

REFERENCE COMMITTEE HEARINGS

Reference Committee hearings are scheduled for Friday, May 2, 1975, at 2:00 p.m.

FRANK R. REYNOLDS, M.D., President
CHALMERS R. CARR, M.D., Speaker
E. HARVEY ESTES, JR., M.D., Secretary
WILLIAM N. HILLIARD, Executive Director

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Vesicoureteral Reflux: Etiology, Significance and Management, John L. Weinerth, M.D., and James F. Glenn, M.D.; An Approach to Increasing Opportunities for Minority Students to Enter Medical Training: Summer Programs in Health Sciences, Evelyn B. McCarthy; Common Obstructive Uropathies of Childhood, D. Patrick Currie, M.D.

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May 1-4—Pinehurst

1975 COMMITTEE CONCLAVE
September 24-27—Southern Pines

Both often



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Associated
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symptoms

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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

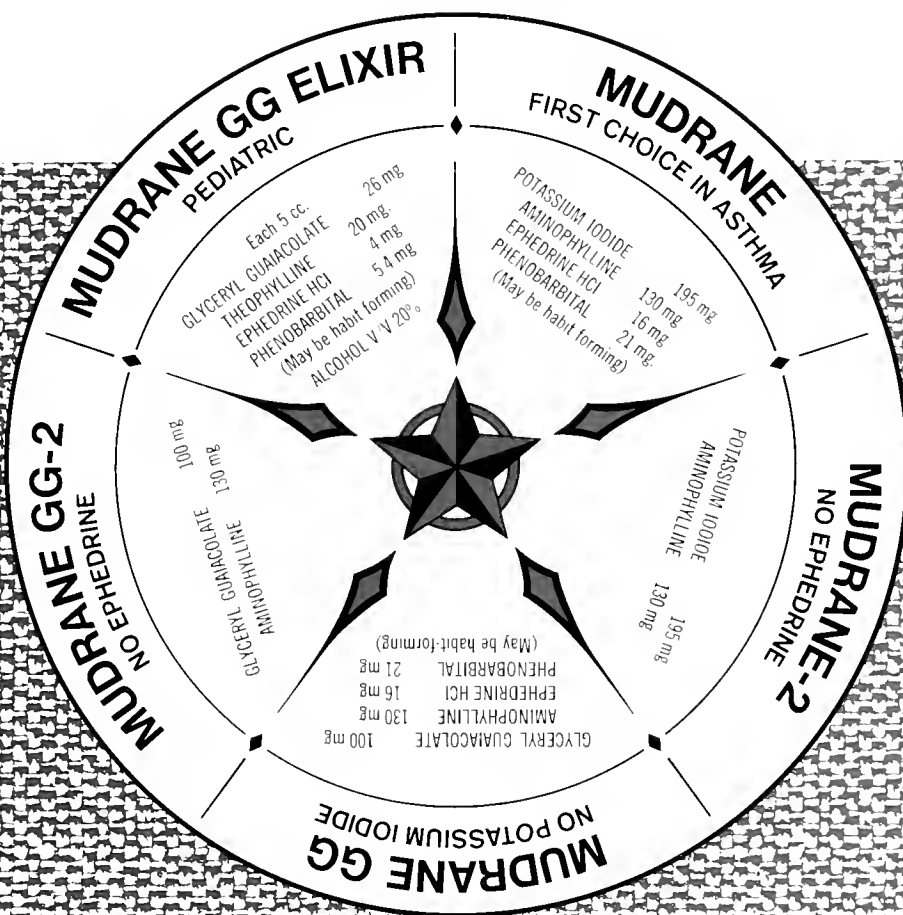
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

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arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdose. Potassium Iodide; Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. **ADVERSE REACTIONS:** Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdose. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

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NORTH CAROLINA MEDICAL JOURNAL

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**AMA Clinical Convention/Honolulu, Hawaii
November 30-December 5, 1975**

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Students, Medical

Vesicoureteral Reflux: Etiology, Significance, and Management

John L. Weinerth, M.D., and James F. Glenn, M.D.

THE diagnosis, significance and appropriate therapy of pediatric vesicoureteral reflux is a controversial subject. Difficulties arise because vesicoureteral reflux has a number of causes and a spectrum of severity and reversibility. The clinical consequences of reflux are influenced by other, sometimes unrelated, processes such as infection and obstruction. To assess and treat pediatric patients with vesicoureteral reflux, all related problems must be evaluated and clearly defined. Dependable diagnosis of reflux, elucidation of individual causes, determination of coexisting abnormalities and formulation of effective therapy are needed.

Vesicoureteral reflux, defined as any return of urine from the bladder to the upper urinary tract, has many causes (Table 1) and ranges from minuscule amounts to massive regurgitation. The ultimate cause of reflux is the absence of an effective valvular mechanism. Hutch¹ and Tanagho²⁻⁴ have outlined the normal anatomic and functional components of the vesicoureteral valvular mechanism. The most important components are (1) the oblique pas-

sage of the ureter through the bladder musculature, (2) the submucosal portion of the tunnel, and (3) the fixation of the ureteral muscular and adventitial components to the trigone at the base of the bladder.

Table 1
Etiology of Vesicoureteral Reflux

Primary Vesicoureteral Reflux (Congenital Anomaly)

1. Lateral ectopia of orifice—malimplantation of ureter into bladder
 - a. Single ureter
 - b. Duplicated ureters
2. Hutch diverticulum—herniation of ureter and orifice into defect of bladder wall

Secondary Vesicoureteral Reflux

1. Neurogenic bladder
2. Bladder outlet obstruction
3. Infection
4. Iatrogenic (surgical)
 - a. Ureteral meatotomy
 - b. Nonantireflux reimplantation of ureter
 - c. Trauma (stone manipulation)

In primary reflux, one or all of these components can be congenitally absent; most often the obliquity of the ureter is lost and the submucosal tunnel shortened. This is especially true in lateral ectopia, a condition in which the orifice is displaced from the midline of the trigone and passage through the bladder wall is almost perpendicular. In the presence of a Hutch diverticulum, the terminal ureter and orifice are often prolapsed into the diverticulum secondary to a defect in the bladder musculature. The deficient

valvular mechanism in this case is secondary to the lack of muscular support.

Secondary vesicoureteral reflux is due to various anatomic defects and disease processes which disturb the delicate interrelationships of the components maintaining the valvular mechanism. Neuropathic disease of the bladder interferes with muscular interaction and contraction, with subsequent disturbance of tunnel elongation and obliquity. Distal obstruction can change bladder muscle thickness secondary to hypertrophy from abnormally high intravesical pressures and subsequent alteration of intravesical ureteric obliquity. Infection causes edema and mechanical dysfunction, leading to decreased pliability of the submucosal ureter and decreased tunnel length.

Iatrogenic reflux can be created by destruction of the submucosal ureter (meatotomy) or by edema from instrumentation (basket extraction of a ureteral calculus). Reimplantations of the ureter which are not antireflux in design might also allow regurgitation of urine from the bladder to the upper urinary tracts.

The diagnosis of vesicoureteral reflux (Table 2) is most commonly made by urologic studies using radiopaque materials instilled into the bladder under various pressures.

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Fluoroscopic control of these studies with videotaping will increase the yield of positive information as well as decrease the overall exposure to radiation. Films taken during the act of voiding and delayed cystographic films have also been helpful in discovering reflux. In addition, Garrett⁵ claims that the demonstration of reflux is increased if the patient is examined in the upright position. Therefore, in all patients who cannot void during the study, a film should be obtained immediately after voiding in private. Reflux is often intermittent, suggesting that it is advantageous to study the child with suspected significant reflux several times to be certain reflux does not exist.

Table 2

Diagnosis of Vesicoureteral Reflux

1. Static cystogram, AP and obliques (low pressure)
2. Voiding cystourethrogram (high pressure)
3. Radioisotope instillation into bladder with subsequent isotopic scanning
4. Cystoscopic Indigo Carmine Test
5. Cystoscopic evaluation of the position and configuration of the ureteral orifices

Vesicoureteral reflux can also be detected by using radioisotopes instead of contrast media.⁶ The isotope solution is instilled directly into the bladder, and standard scanning methods are employed to detect radioactivity in the ureters and kidneys; because of relative expense, time involved and lack of precise definition, this method is not often used.

A direct visual method has been applied successfully in some cases in which reflux was not demonstrated by cystourethrography. Amar⁷ reported a simple test which has been remarkably effective in the discovery of reflux. The bladder is filled with dilute indigo carmine and then emptied either by voiding or catheter drainage. At the end of the emptying phase the cystoscope is immediately placed into the bladder and the ureteral orifices are observed. Blue dye coming from either ureteral orifice necessarily comes from refluxed urine, and the amount returning to the bladder provides some indication of the degree of reflux.

Careful descriptions of reflux are valuable in evaluating and following these patients because the volume of reflux can range from small amounts regurgitated into the distal ureter to large quantities leading to marked hydronephrosis; therefore, the amount of ureteral and pyelocalyceal dilation, the extent of calyceal blunting and the degree of cortical loss should be carefully ascertained. This information is important in detecting upper tract damage at the initial evaluation and in determining the stability of the upper tracts during follow-up.

When vesicoureteral reflux has been discovered in a patient, its significance needs to be defined as it relates to the particular patient. It has been proposed that in very young children minimal vesicoureteral reflux may be a transient and unremarkable event.⁸ Considering the elaborate structure and physiology of the vesicoureteral valvular mechanism, it is not unreasonable to assume that there is a maturation process which may obviate the reflux encountered in neonates and young infants. Reflux resulting from specific anatomic and congenital defects—lateral ectopia and Hutch diverticula, for example—will not be overcome by maturation; it is therefore important that the urologic evaluation be complete enough to rule out such conditions.

The effect of vesicoureteral reflux on renal function and anatomy in the absence of infection must also be considered. Several authors^{9, 10} following Stephens¹¹ have thought that low-grade reflux without upper tract dilation does not produce progressive renal deterioration. However, recently Stephens has indicated that there may be a "water hammer" effect, especially when ureters are more than minimally dilated.¹² The previous rationale for a conservative approach to children with reflux but no infection may need to be revised as experience accumulates.

Persistent reflux in the presence of recurring or persistent infection does lead to progressive renal deterioration, both functional and anatomical, which appears to be direct-

ly related to the magnitude of reflux noted at the time of initial evaluation. Children with upper tract dilation demonstrate progressive deterioration in renal function, whereas children with reflux but no dilation show significantly less deterioration.¹³ The urologist must select the initial therapy for children with reflux and infection, knowing that spontaneous cessation of reflux will occur in approximately one-third of the children having urinary tract infections sterilized by appropriate antibiotics.¹⁴

The contribution of urinary obstruction to the clinical course of vesicoureteral reflux is most important in children with concomitant infection. Lenaghan and Cussen¹⁵ have demonstrated in animals that obstruction does not delay the spontaneous maturation and cessation of reflux. It is possible that under sterile conditions, coexisting obstruction and reflux will not adversely affect renal function. It has been suggested that obstruction itself does not cause vesicoureteral reflux,^{11, 16} but it is recognized that surgical correction of reflux on one side occasionally leads to the initiation of reflux on the contralateral side.¹⁷ Whether this is due to surgical interference with the trigonal attachments during the first surgery or from persistent obstruction is not clearly documented.

Since obstruction leads to increased frequency of infections and derangement of the bladder musculature, it should be relieved. The most commonly diagnosed urinary obstruction appears to be distal urethral stenosis. The studies of distal urethral stenosis are somewhat suspect since the antibiotic regimens of the groups of patients operated on and those not operated on were not comparable.¹⁸ However, a 90 percent cure rate in girls treated by internal urethrotomy after 18 months, followed by three months of antimicrobial therapy, has been reported.¹⁹

The interpretation of the significance of vesicoureteral reflux depends on its magnitude, the anatomic state of the upper tracts and the presence of infection or obstruction.

In addition, in certain patients the ureterovesical valvular mechanisms will not mature because of congenital defects which can be corrected only by surgery. Children with minimal reflux and easily controlled infections have the best prognosis. Conservative management allows many children to overcome reflux and avoid structural damage to their kidneys.

Children with persistent infection, obstruction or congenital ureteral malimplantation in the presence of infection are at greatest risk. These children should have their obstructions relieved and their infections adequately treated by administration of appropriate antimicrobial agents. Their responses to therapy should be carefully evaluated by periodic urine cultures and appropriate radiographic studies.

With the exception of very mild lateral ectopia, ureteral malimplantation with reflux should be corrected as soon as possible. Persistent infections and evidence of deteriorating upper tracts are indications for early correction of the ureteral valvular mechanism.

Children with documented reflux should have a complete urologic examination to rule out neurologic dysfunction, obstruction and urologic anatomic defects, and those with massive reflux and dilation of their upper urinary tracts should be treated surgically. Children with lesser degrees of reflux should have coexisting abnormalities corrected, if possible, and should be treated with appropriate antimicrobial agents. At

regular intervals during the period of antimicrobial therapy, documentation of the absence of reflux and the maintenance of normal renal function should be obtained. If renal anatomy and renal function remain stable in the presence of low-grade reflux and sterile urine, further non-surgical management might be justified.

If renal function deteriorates, or if infection persists with reflux, surgery to protect the upper urinary tracts from progressive pyelonephritis seems to be indicated. The responsibilities to children with this particular genitourinary defect are manifold. All possible etiologic factors involved in reflux and infection must be identified in order to provide intelligent long-term management. The children must not be operated on until these factors have been identified. Long-term followup is necessary since there is a significant number of patients who continue refluxing and have recurrent urinary tract infections with risk of increasing renal damage. Finally, periodic reappraisal of the efficacy of primary management must be made in order to identify those children for whom conservative non-surgical regimens fail. These children should be offered ureteral reimplantation procedures which have proved to be highly effective in protecting the upper urinary tracts from infected reflux.²⁰⁻²²

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"I must own I set most by good candle light," said Mrs. Martin. "'Tis no expense to speak of where you raise the taller, and it's cheerful and bright in winter time. In old times when the houses were draftier they was troublesome about flickering, candles was; but land! think how comfortable we live now to what we used to! Stoves is such a convenience; the fire's so much handier. Housekeepin' don't begin to be the trial it was once."

"I must say I like old-fashioned cookin' better than oven cookin'," observed Mrs. Jake. "Seems to me 's if the taste of things was all drawed up chimblly."—*A Country Doctor*, Sarah Orne Jewett, 1884. p 10.

An Approach to Increasing Opportunities for Minority Students to Enter Medical Training: Summer Programs in Health Sciences

Evelyn B. McCarthy*

SINCE June 1971, the University of North Carolina School of Medicine has hosted four educational summer programs designed to increase the opportunities for minority students to enter health professional training. For three years, the School provided instructional facilities, faculty and administrative staff, as a member of a consortium organized to support the North Carolina Health Manpower Development Program (NCHMDP). The NCHMDP programs sought students interested in a variety of health careers. When NCHMDP project funds were terminated, the School operated a program in 1974 for its incoming minority students and 20 pre-medical candidates.

These programs were a response to the problems of enrolling increased numbers of minority and disadvantaged students in existing training programs. Special efforts were needed to recruit and reinforce students from discouraging socioeconomic environments. The programs have now provided more than 200 minority students with rigorous

academic training and increased motivation to pursue their goals.

THE NEED

The health care needs of underserved communities and the shortage of minority health professionals have been clear. In 1970, the United States had a ratio of one Black physician or dentist to 3,000 Black people, compared with one White doctor or dentist to 300 White people. The census identified 55 American Indian doctors and 865,000 American Indians, a ratio of one to 14,500. At the same time, 1,178 Black, American Indian, Mexican American and Puerto Rican students were enrolled in United States medical schools—3.1 percent of the enrollment—but as of 1972-73, more than one-fifth were in the nation's two predominantly Black medical schools.¹

In 1968, North Carolina had 118 Black physicians—one Black physician to 8,500 Black people; 12 rural counties with a Black population of about 40 percent and no Black physicians; and one region with 25,000 Black residents and only one Black doctor.² Figures for 1973-74 show a small increase to 125 practicing Black physicians. Indian communities have even fewer representatives. According to the most recent Federal and state figures, there are more

than 44,000 American Indians in the state and only three practicing Indian physicians.

Before 1970, the three medical schools in North Carolina typically graduated no more than one or two Black students a year. The University of North Carolina School of Dentistry graduated its first Black student in the class of 1975. Five North Carolina Indians are now enrolled in state medical schools, and 20 Black students are in the class of 1978 at the University of North Carolina School of Medicine. These recent increases in admission are the result of continuing efforts, like the summer programs, to recruit and train more minority professionals.

PURPOSE AND NATURE OF PROGRAM

To assist minority students to compete for admission to health schools and to prepare for professional studies, the summer programs have sought to (1) provide demanding work in related sciences; (2) strengthen advanced level study skills; and (3) develop realistic understandings of career opportunities through clinical experiences, seminars on health issues and admissions questions, pre-professional counseling, and interaction with health professionals and minority students already in health programs. The pro-

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grams also hoped to increase appreciation of the urgent needs for health professionals in inner city and rural communities.

The core of each student's summer work has been two or more substantial basic science courses, required study skill materials, and clinical orientation related to a proposed career. Although the curriculum has varied from summer to summer according to the needs of a changing student body, all courses have been designed and conducted by regular health faculty. Pre-professional courses such as organic chemistry, biochemistry, medical microbiology and physiology have covered required college-level material. Courses such as biostatistics, pathology and dental orientation have introduced professional studies. The 1974 program (for pre-medical students only) emphasized the first year medical areas of bacteriology, biochemistry, histology and pathology.

Careful evaluation of student performance was an important feature. The faculty used defined academic criteria and achievement-based tests to help students realistically assess their preparation. In addition, program reports could provide objective data about pre-professional competence to support applications to health schools.

STUDENTS

In today's competition for admission, there are no guarantees of success for seemingly qualified candidates. Given a goal of increasing minority candidates to health schools, a first criterion for admission to these programs was the student's serious interest in a health career. Sustained personal contact, however, was essential to successful recruitment, particularly among Appalachian White and Native American students.

The three NCHMDP programs integrated students with very different educational preparation and career orientations, ranging from those with only one or two years of general college, hoping to enter a baccalaureate degree program (nursing, pharmacy and allied

	1971	1972	1973	1974
Numerical and Geographical Distribution				
Total number of students enrolled	37	77	43	44
North Carolina	100%	75%	58%	100%
Out-of-State	—	25%	42%	—
Racial or Ethnic Background				
American Indian (Lumbee)	1	5	1	7
Black	35	49	29	36
Spanish-speaking	—	12	11	1
Oriental	—	1	—	—
White	1	10	2	—
Health Career Interests				
Medicine	21	30	21	40
Other health fields	16	47	22	4
Health Career Status at End of Summer				
(a) Entering professional programs in:				
Medicine	8	8	7	20
Dentistry	1	2	—	4
Public Health	2	7	3	—
Graduate level sciences	—	1	2	—
Undergraduate degree programs	6	12	9	—
(b) Applying to health profession programs in next two years				
	19	30	17	20
(c) Other (below junior year, or no decided field of interest)				
	1	17	5	—

health sciences), to college seniors and graduates aspiring toward post-graduate programs (medicine, dentistry and public health). Although the majority of students were Black North Carolina residents, with a dominant interest in medicine, the programs sought to include all minority groups and some out-of-state applicants, primarily from the south (Table 1). Students reported a beneficial psychological impact from living for ten weeks in a racially mixed group with similar questions and problems, as well as a new appreciation of the health team concept.³

EVALUATION

At the end of each summer, the students were an essential resource for internal evaluations. Their written comments have reflected definite encouragement to pursue health careers, new perspectives on health careers and opportunities for admission, and increased motivation, as well as confidence that their academic work would strengthen their health school applications. Student responses to questionnaires also indicate that the summer experiences clarified critical health care needs for at least 75 percent of the participants and, for more than 60 percent,

increased their orientation to service in shortage areas.³

Comprehensive studies of the effects of the summer programs on students' progress toward health careers have been limited by lack of funds. The program staff conducted two surveys, however, and has maintained personal contact with many students, particularly those attending near-by North Carolina colleges.³

As of January 1974 (Table 2), at least 45 percent of the students from the first three programs were enrolled in health training programs. Almost all were in good academic standing, and their progress compared favorably with that of other minority students. Twenty-three percent were still in pre-professional training in 1973-74, but nearly three-fifths of this group reported admissions for September 1974. A small number postponed plans for health training, generally because of marriage or financial difficulties. As of September 1972, the remaining 25 percent were continuing pre-professional studies or enrolling in health schools, but a confirmation of their status was not obtained in 1974 (Table 2).

Although most former participants are still in pre-professional

Table 2
Health Training Status of Former Participants as of January 1974

	Progress Unconfirmed*	In preprofessional program	Applying for 1974	First year professional	Second year professional	Third year professional	In professional program—(level unknown)	Graduate from professional program	Total in each health field
Medical School	13	8	8	11	7	6	2		55
Nursing School	4		4	4	5				17
Dental School	1	1	2	2	2	1			9
School of Public Health	8	1	2	4	3		1	4	23
Pharmacy School	2			2			1	1	6
Graduate Science Program				2	2				4
Medical Technology	1			1	2			1	5
Speech Therapy					1				1
Psychology		2							2
Occupational Therapy			2						2
Health Education		3			1				4
Hospital Administration			1						1
Other Allied Programs	2		1						3
Podiatry	2								2
Totals	33	15	20	26	23	7	4	6	134

No Health Career Plans
at this time—10

Status Completely Unknown—5

* Last known to be completing undergraduate preparation and/or making applications in these fields. No information received about progress since September 1972.

and professional training, a tentative predictor of success may be found in faculty evaluations of the 1973 and 1974 students. The majority of participants have not come from well-known competitive colleges, and their previous transcripts ranged from adequate to extremely problematic educational records. It seems significant, therefore, that the

faculty have found the summer program students to be generally comparable to other students they had taught and, in some cases, comparable to above-average or superior students (Table 3).³ In 1974, both pre-medical candidates and students entering the North Carolina School of Medicine class of 1978 demonstrated ability to handle first-year

Table 3
Faculty Ratings of 1973 Participants*

Course & Enrollment	Superior	Above Average	Average	Below Average but Satisfactory	Unsatisfactory
Biochemistry (10)	3	3	1	3	—
Biostatistics (6)	—	3	1	2	—
General Studies (44)	1	10	13	4	12†
Microbiology (19)	6	7	5	1	—
Organic Chemistry (14)	2	5	5	2	—
Pathobiology (19)	1	3	4	6	3
Physiology (21)	—	2	10	4	2

* Summarized faculty ratings in response to the question, "How would you describe the overall performance of this student compared with other professional or pre-professional students you have taught?" The total of ratings does not correspond to course enrollment if an instructor used written comments instead.

† Unsatisfactory ratings in General Studies represent students who did not complete required self-study materials.

medical studies, as measured by systematic examinations modeled on the National Medical Boards. While the caliber of minority students applying to medical school seems to be improving, faculty believe that this kind of summer experience has been a major factor for many.

PROBLEMS AND LIMITATIONS

Adequate funding, particularly grants to cover direct student expenses, has been a problem. The programs are concerned with students for whom financial survival has been a constant barrier to educational and career goals. With no family resources, most rely on loans and jobs for college expenses and must sacrifice summer earnings to attend the program. A number have other complications, such as families to support. This financial reality must be taken into account in any effort to identify and recruit more minority students into health training programs.

Another limitation has been the lack of continuity for counseling and studies of participant progress to establish key factors contributing to their success. Analyses of existing data and additional research into learning difficulties are needed. Although funds for student support remain a major concern, the School of Medicine, through the Office of Medical Studies, is addressing these issues and will continue a similar program. The NCHMDP, as a part of the General Administration of the State University System, is now assisting other campuses in planning recruitment, counseling and academic reinforcement of promising students; a 1974 project placed 56 students in clinical work-study positions to provide direct experience and motivation for health training.

SUMMARY

The summer programs conducted on the campus of the University of North Carolina School of Medicine have demonstrated that a concentrated academic effort during eight to ten weeks can successfully increase the number of minority students who progress steadily through

pre-professional studies, competition for admission and professional training. There is no simple cause-and-effect relationship between participation in the summer programs and these educational achievements, but participants have expressed their belief that participation has been a significant factor in their ability to define and attain their health career goals. Some say they would have given up their aspirations. Instead, within the next few years, they will

become professionals in the national health care system, where they are urgently needed.

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These country neighbors knew their friends' affairs as well as they did their own, but such an audience is never impatient. The repetitions of the best stories are signal events, for ordinary circumstances do not inspire them. Affairs must rise to a certain level before a narration of some great crisis is suggested, and exactly as a city audience is well contented with hearing the plays of Shakespeare over and over again, so each man and woman of experience is permitted to deploy their well-known but always interesting stories upon the rustic stage.—*A Country Doctor*, Sarah Orne Jewett, 1884, p 16.

Common Obstructive Uropathies of Childhood

D. Patrick Currie, M.D.

CONGENITAL anomalies occur more commonly in the genitourinary tract than in any other organ system and are major causes of obstructive uropathy which constitute 90 percent of urologic problems in children. The obstruction, anatomical or neuromuscular, is most often found at the distal urethra in girls, at the posterior urethra in boys, the ureterovesical junction, or ureteropelvic junction, and may have been present from three months gestation when urinary excretion begins.

Besides stasis and obstruction, state of health and the presence of gram-negative organisms, principally *Escherichia coli* and *Proteus vulgaris* which usually spread via an ascending route, are primary factors in infection. Structural and functional injury caused by urinary back pressure and infection affect the kidneys as well as the collecting system. The renal parenchyma is compressed between the dense fibrous capsule and the distended pelvis so that intrarenal vascular supply is compromised and atrophy of the glomeruli, convoluted tubules and

progressive dilatation of the collecting tubules are seen.¹

Symptoms vary depending on the type and location of the obstruction; frequency and dysuria are common in children with lower tract infection while pyuria, fever, pain, hematuria, and abdominal mass are more indicative of hydronephrosis. About half the children with obstruction have gastrointestinal problems, and in severe cases uremia may occur. It should be kept in mind that vesico-ureteral reflux with hydronephrosis and other nonobstructive states may appear to be primary obstructive uropathies.

Diagnosis may be made from the history, physical examination including observation of voiding, intravenous pyelogram, cystourethroscopy, retrograde pyelography, urethral calibration and cystourethroscopy, hematology and bacteriology studies, as well as renal function and electrolyte assessment; cinefluoroscopy is indispensable. Treatment varies, depending on severity, type and location, but renal function must be improved by either primary relief of the obstruction or diversion and antimicrobial therapy. The prognosis depends on the degree and duration of the obstruction, as well as the reversibility of the functional damage.

COMMON CHILDHOOD UROPATHIES

Male urethral meatal stenosis

The incidence of meatal stenosis, estimated as high as nine percent,² may be congenital or due to circumcision or injury to the meatus by rough diapers. In a newborn, the average size of a meatus is a No. 8 French; if less than No. 6 French, it is considered to be stenotic. If severely stenotic, dilatation of the proximal urinary tract and renal function deterioration can occur. The usual findings are bloody spotting and crusting of the meatus, caused by infection and ulceration just inside the obstructed orifice. Treatment is meatotomy and daily dilatation for two to three weeks.³

Female distal urethral stenosis

Bladder outlet obstruction, long attributed to congenital bladder neck obstruction, has been demonstrated by Lyons and Smith⁴ to be more commonly caused by congenital urethral stenosis with secondary spasm of the striated external sphincter. They showed that stenosis (urethral ring) is absent at birth, but within a few months develops as a normal anatomical structure and after puberty disappears, implying that absence of estrogens leads to its development.⁴ The urethras of un-

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selected patients of ages newborn to five, six to nine, and ten to 14 years were shown to have mean calibrations of No. 15 F, No. 17 F, and No. 22 F, respectively.⁵ Although treatment of the urethral ring varies, lysing the ring by over-dilatation or internal urethrotomy has been successful in about 90 percent of cases, with cessation of enuresis, restoration of normal free voiding pattern, cure of recurrent cystitis or persistent bacteruria, and at times disappearance of vesicoureteral reflux in borderline ureterovesical valve embarrassment.⁶⁻⁹

Posterior urethral valves

Posterior urethral valves, the most common cause of congenital urethral obstruction in boys, are deep hypertrophic mucosal folds. William et al¹⁰ reported that the earlier the symptoms the greater the severity; half their patients with posterior urethral valves were seen during the first three months of life, and 70 percent during the first year. Symptoms and signs include frequency, dribbling, incontinence, retention and infection, palpable bladder and poor urinary stream; infection and uremia may be observed. Definitive diagnosis is made by voiding cystourethrography (Figure 1) and cinefluoroscopy or urethroscopy. Treatment depends on the severity of the obstruction and the health of the patient. A child with severe hydronephrosis and poor renal function should have upper urinary diversion to ensure maximal drainage and stabilization. Infants who have mild obstructions



Fig. 1. Voiding cystourethrogram demonstrating posterior urethral valves.

and are otherwise healthy may be cured by primary resection of the valves. Mortality for patients with posterior urethral valves has been reported as high as 25 percent; therefore, prompt recognition and treatment are essential.¹⁰⁻¹²

Congenital neurogenic bladder

Congenital neurogenic bladder is usually caused by myelomeningocele, but sacral deformities often associated with neurogenic bladder, as well as birth trauma and cerebral palsy, may also be causal or etiologic. The incidence of myelomeningocele is about three in 1,000 births, and more than two-thirds survive with neurosurgical and urological treatment. At initial evaluations, 62 percent of patients with a congenital neurogenic bladder have a normal intravenous pyelogram, whereas 13 percent have hydronephrosis, and 36 percent have vesicoureteral reflux.¹³ Many such patients have hypertonic spastic bladders as well as atonic bladders.¹³ Therapeutic aims are to preserve renal function, control or eliminate infection, and establish adequate control of urine flow. Short-term nonsurgical treatment has improved, but the majority of these children require urinary diversion.¹⁴

Duplication of the ureter

Duplication of the ureter (Figure 2) occurs in approximately one in 160 infants and is twice as frequent in girls as in boys. It can be associated with other urinary anomalies, and may be incomplete or complete, depending upon whether the ureters join outside the bladder or enter the bladder separately: in incomplete duplication, an accessory ureter grows upon the side of the normal ureter; in complete duplication, an additional ureteric bud forms upon the parent Wolffian duct or mesonephric duct. Unilateral, incomplete duplication is more common than bilateral, complete duplication, and ureteral bifurcation occurs in the pelvis in 50 percent of reported instances. In complete duplication, the ureter draining the upper pole opens close to the bladder neck, whereas the ureter draining the lower pole

opens laterally and proximally along the trigone. Complete duplication is often asymptomatic and nonpathological; however, a variety of associated malfunctions may result from either or both ureters. Because of the relatively short intravesical ureteral segment of the lower pole ureter, reflux can occur, while the upper pole ureter may terminate in either an intravesical or extravesical ureterocele. Even without ureterocele formation, the upper pole ureter may open ectopically into the urethra, vagina, uterus or vestibule in girls (Figure 2), or in the posterior urethra, vas deferens, and seminal vesicle in boys. Thus, with the development of ectopic upper renal segment ureters, incontinence may be the presenting complaint in girls. Incontinence however is unusual in boys since the ureter opens proximal to the external sphincter; epididymitis or enlarged seminal vesicle on that side is common. Treatment includes ureteral reimplantation, heminephroureterectomy, pyelopyelostomy with resection of the ectopic ureter, or ureterocelelectomy.¹⁵

Ureterocele

Ureteroceles (Figure 3) are cystic dilations of the distal ureter involving its wall. Externally, they are covered by the vesical mucosa and internally by the ureteral mucosa; between these layers are diffusely scattered muscle fibers and connective tissue. A variety of ureteroceles

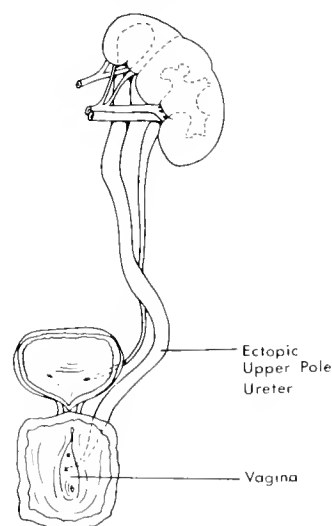


Fig. 2. Ureteral duplication with an ectopic upper pole ureter.

has been reported in up to four percent of infants examined; in 15 percent they are bilateral; in more than two-thirds they are associated with ureteral duplication involving the upper segment;¹⁶ and they are more common in females. They vary in size, location, and degree of obstruction, but those confined intravesically are less severe than ectopic ureterocele, which are usually larger and obstructing. They may cause obstruction to the renal segment that they drain and to the contralateral ureter and bladder neck. Diagnosis is made by intravenous pyelography, cystography, and cystoscopic examination^{17, 18}; a typical "cobra head" deformity can be seen on X-ray. Simple ureteroceles may not require treatment, but treatment of complicated ureteroceles may be done by ureterocelectomy and reimplantation of the ureter, and occasionally nephroureterectomy is necessary for removal of the markedly damaged renal segment.^{19, 20} Cystoscopic meatotomy is usually unsatisfactory.

Primary megaloureter

A primary cause of hydronephrosis in infancy is obstruction at the ureterovesical junction, usually resulting from an adynamic ureteral segment (Figure 4A), and affecting three times as many boys as girls. Typically, the ureteral orifice is of

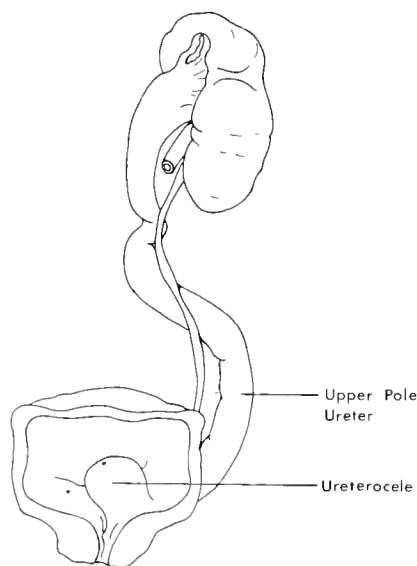


Fig. 3. Ureteral duplication with ureterocele involvement of the upper pole ureter.

normal size (functional obstruction can be seen by fluoroscopy), the proximal dilated ureter is hypertrophied, and the adynamic or aperistaltic segment appears to have greatly increased fibrous tissue and collagen fibers in the lamina propria as well as between the ureteral muscle. Excessive collagen reduces ureteral distensibility so that with diuresis the rate of urine flow into the bladder cannot increase proportionally; therefore, dilation of the proximal ureter and pelvis can occur. This condition develops (1) in the lower ureter near the ureterovesical junction, and (2) in the upper ureter near the ureteropelvic junction²¹ (Figure 4). Diagnosis is made by retrograde ureteral catheterization and cinepyelography. Treatment varies according to the size of obstruction; eradication of infection sometimes stabilizes the process, but resection of the involved segment and ureteroneocystostomy, occasionally necessitating ureteral shortening and tapering, is more often required.²²

Primary hydronephrosis

Ureteral pelvic junction obstruction is classically attributed to strictures, aberrant vessels, high insertion of the ureter and obstructing fibrotic bands. From our series, it has become increasingly apparent that the most common cause of ureteral pelvic junction obstruction is an adynamic ureteral segment (Fig-

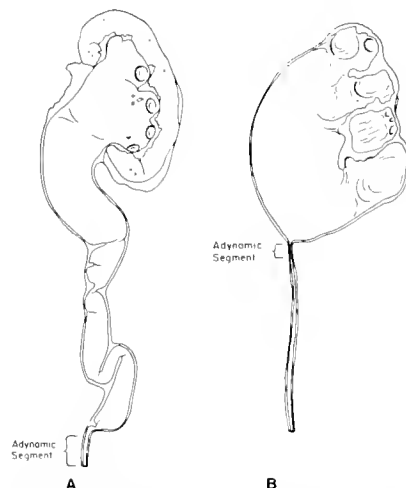


Fig. 4. Adynamic ureteral segment: (A) ureterovesical junction obstruction, (B) ureteropelvic junction obstruction.

ure 4B), appearing to be a stricture with progressive dilatation of the pelvis caudally. Occasionally posterior vascular crossings with kinking ureters produce an obstruction. The patient may be asymptomatic since these hydronephrotic pelvises are usually uninfected. Typically, these patients present with pain after a large fluid load or hematuria from minimal trauma; bilateral ureteropelvic junction is common. Since reflux can appear as a primary hydronephrosis, cystography is mandatory. Treatment by surgical revision of the ureteropelvic junction is indicated and the type of pyeloplasty is dictated by the nature of the obstruction. For the adynamic ureteral segment, excision and dismembered pyeloplasty are the usual treatment. A surgically acceptable neoureteropelvic junction is anatomically dependent, funnel shaped, and of adequate size.

SUMMARY

The pathophysiology, symptomatology, diagnosis and treatment of common obstructive uropathies of childhood have been reviewed. The most important goal in their treatment is preservation of renal function through reduction of the deleterious hydrostatic back pressure and suppression of infection. Awareness of these congenital malformations is necessary for prompt diagnosis and life-saving therapy.

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"I call that pretty cider," said Martin: "'t is young yet, but it has got some weight a'ready, and 't is smooth. There 's a sight o' difference between good upland fruit and the sposhy apples that grows in wet ground. An' I take it that the bar'l has an influence: some bar'ls kind of wilt cider and some smarten it up, and keep it hearty. Lord! what stuff some folks are willin' to set before ye! 't ain't wuth the name o' cider, nor no better than the rensin's of a vinegar cask."

"And then there's weather too," agreed Mr. Jacob Dyer, "had ought to be took into consideration. Git your apples just in the right time—not too early to taste o' the tree, nor too late to taste o' the ground, and just in the snap o' time as to ripeness'. on a good sharp day with the sun a-shining; have 'em into the press and what comes out is cider. I think if we've had any fault in years past, 't was puttin' off makin' a little too late. But I don't see as this could be beat. I don't know's you feel like a pipe, but I believe I'll light up," and thereupon a good portion of the black-looking tobacco was cut and made fine in each of the hard left hands, and presently the clay pipes were touched off with a live coal, and great clouds of smoke might have been seen to disappear under the edge of the fire-place, drawn quickly up the chimney by the draft of the blazing fire.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 22-23.

Editorial

HYSTERIA 1975

In our modern society, striving for sophistication, we seek rational explanations for social, economic and medical disruptions, and act accordingly. So when in May 1973 an acute and bizarre outbreak in the elementary school in Berry, Alabama, a small community in a poor section of the state, led to evacuation of more than 50 of 98 victims to the county hospital emergency room in nearby Fayette, an opportunity was provided for an epidemiologic survey¹ which indicated that mass hysteria had erupted. The manifestations—itching, a mysterious rash, headache, nausea, weakness, abdominal pain, fainting, numbness and shortness of breath—without evidence of organic disease, and their occurrence in the absence of suggestions of infections, toxic and allergic etiology pointed strongly to such a diagnosis, and the waning of reactions after school was closed gave added support.

While classical psychoanalysis holds that sexual repression with inadequate resolution of conflicts is responsible for hysteria, its occurrence in grammar school children might demand greater sexual precocity than even our pudendally preoccupied society recognizes, so we must seek elsewhere for explanations. If this episode had occurred in Tudor or Stuart England,² or even in Salem, Massachusetts, in 1692,³ spirit intrusion with devil possession would have been a perfectly sensible explanation and members of the devil's cadre sought in the community. The bewitched would have been beseeched to identify witches, wizards and warlocks abroad so that exorcism might be practiced by any means at hand. As in Salem and elsewhere, legal measures might have been carried out and the villains burned at the stake and otherwise ostracized. The devil theory would be confirmed, the forces of darkness vanquished and the righteous rewarded by sure knowledge of election and immunity.

But what if institutions become possessed by real devils, and provisions for treating society are inadequate? Supernatural phenomena being no longer acceptable explanations, we might turn to law and turn the rascals out, or we could select racial and religious groups as scapegoats, blaming them for our own uncertainties. Or we might, as in England today according to a recent *Wall Street Journal* report, return to exorcism for individuals whose internal reality is out of place. One vicar of the Church of England has been performing the ritual of exorcism up to ten times a week, and in 1973 the Bishop of London appointed a senior clergyman as an advisor in such matters because of estimates that two percent of mental problems may be treated in this way. Astrologers, too, seem to be responding to the needs of the psyche, there having been a 50 percent increase in two years in membership of the American Federation of Astrologers⁴ who doubtless will soon be seeking Medicare and Medicaid benefits for their clientele.

Early physicians combined the healing roles of priest, magician and rational therapist, so we should not be surprised in this scientific era that others should rush in to carry out the functions we have relinquished. After all, folk medical beliefs persist⁵ and remedies befitting the hypotheses advanced in such systems evolve. The problem for the physician still lies in recognizing the nature of the process and his patient's reaction to it.

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Emergency Medical Services



THE AMA COMMISSION ON EMERGENCY MEDICAL SERVICES AND THE EMERGENCY MEDICAL TECHNICIAN

**Eugene L. Nagel, M.D., Chairman, and
William E. Burnette, Secretary**

The AMA Commission on Emergency Medical Services was created in October 1966, and is now represented by 12 specialty societies interested in emergency health care. It is charged with identifying and coordinating the implementation of programs within the specialty medical societies as they relate to professional education, educational standards, and training programs for allied emergency personnel.

The development of an organized, pre-hospital emergency care system had its origin in physician house-calls, in American Red Cross first-aid and in military medicine. The concept of emergency care extending into medical care and not just first-aid began with corpsmen, pharmacist mates and specially trained paramedics in the field. By the early 1960s, the attention had been concentrated on early medical treatment of the critical victim still in the field. Simultaneously, monitoring and earlier definitive treatment for the high risk coronary patient evolved, making it easy to apply these methods to programs for emergency care.

In 1967, the training of emergency care personnel was a local, largely disorganized affair, with some help from the Committee on Trauma of the American Academy of Orthopedic Surgeons courses, which about 15,000 persons have attended. It soon became

clear that emergency care personnel should be trained in some standardized manner satisfying minimal requirements. By 1969, the United States Department of Transportation's 81-hour course was approved and made available to all states.

The testing of the EMT, emergency medical technician candidate, would have to be uniform if the classification were to have meaning. Fourteen organizations agreed to sponsor the Registry for Emergency Medical Technicians. By 1974, approximately 35,000 people took the examination, with a failure rate of 30 percent.

The EMT is a health specialist involved in emergency health delivery in the field or before hospitalization. Under consideration by the Registry is a new term for advanced technicians, EMT-Paramedic, which would require approximately one year of study.

At the most recent meeting of the Commission, it was unanimously recommended that the EMT be recognized as employed in an emerging health occupation. This should place the EMT among the 25 other allied health specialties already recognized, including respiratory therapists, laboratory technicians and radiologic technicians.

—Abstracted by George Johnson, Jr., M.D.

From "Emergency Medicine Today," Vol. 3, No. 1, January, 1975, John M. Howard, M.D., Editor. Original article may be obtained from Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

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 Lonon, Robert Warren, Jr., MD (GP), ASU Health Service, Boone 28607
 Miranda, Conrad Jonathan Resus, IV, MD (GS), Rt. 1, Box 229-B, Burgaw 28425
 Naman, Carl Hawkins, MD (GS), 1200 Hardin Dr., Shelby 28150
 Nesbitt, James Monroe, Jr., MD (PD), Ashe Mem. Hospital, Jefferson 28640

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 Woodworth, Thomas Bell, MD (GP), 1611 Owen Dr., Fayetteville 28304

WHAT? WHEN? WHERE? In Continuing Education

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician's Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

April 18

Behaviorism and Psychoanalysis Seminar

Place: Babcock Auditorium

Time: 9:30 a.m.-4:00 p.m.

Credit: 5 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 19

Community Stroke Care and Rehabilitation—a seminar for physicians

Place: Babcock Auditorium

Sponsors: North Carolina Heart Association; Bowman Gray School of Medicine

Fee: \$10

Credit: 4½ hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean
for Continuing Education, Bowman Gray School of
Medicine, Winston-Salem 27103

April 21-22

Primary Nursing: Participants will explore the use of the primary system and its relationship to other systems, and identify its influence on the nursing process, patient care and staffing.

Fee: \$50; James M. Johnston Awards available. Enrollment limited to thirty-two RNs

Recognition: 12 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 21-24

Recent Advances in Allergy

Place: The Homestead, Hot Springs, Virginia

Seminar sessions will be held from 8:00 to 10:00 on each of these four days.

For Information: Claude A. Frazier, M.D., Building 4, Doctors Park, Asheville 28801

April 23-25

The Nurse: Planning Classes for Expectant Parents

Designed to assist nurses to conduct classes for parents in prepared childbirth.

Fee: \$75; James M. Johnston Awards available up to one-half of fee, based on need. Registration limited to 16 nurses.

Recognition: 18 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

April 24

Infectious Disease: Craven-Pamlico Annual Medical Society Symposium

Place: Ramada Inn, New Bern

Sponsor: Craven-Pamlico Medical Society

Fee: Participants and their spouses will be guests of the Society for the Symposium, including the social hour and banquet

Credit: 5 hours; AAFP credit approved

For Information: Zack J. Waters, Jr., M.D., Box 1089, New Bern 28560

April 29-May 2

Leadership for the Health Professional

Place: Lambuth Inn, Lake Junaluska, Waynesville

Sponsors: WCU Department of Nursing; Health Education Commission of Western North Carolina

Registration: limited to approximately 24; priority given to Directors of Nursing or their designees

For Information: HEC-WNC, Post Office Box 7607, Asheville 28807

May 1-4

121st Annual Session of the North Carolina Medical Society: General Session on Scientific Subjects and Specialty Section Meetings

Place: Pinehurst Hotel and Country Club

For Information: Mr. William N. Hilliard, Executive Director, P. O. Box 27167, Raleigh 27611

May 6 & 8

Toward More Effective Diabetic Teaching

Place: May 6—Holiday Inn, Reidsville

May 8—Town & Country Restaurant, Williamston

Fee: \$24 (includes lunch); James M. Johnston Awards available

Recognition: 6 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 7-14

Medical Seminar Cruise

Place: Sailing from Charleston, South Carolina, and calling on the ports of San Juan and St. Thomas

Sponsors: North Carolina Medical Society; South Carolina Medical Society; Division of Continuing Education of the Medical University of South Carolina

Fee: \$100 deposit to insure reservation; cabin rates from \$360 to \$640

Credit: 20 hours AMA Category I (correction from previous information)

For Information: Medical Seminar Cruise, Southern International Travel Corporation, P. O. Box 19372, Raleigh 27609

May 8-10

Eighth Annual Workshop on Arterial Metabolism Research
Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 12-13

Family Planning Seminar

Place: Old Well Room, Carolina Inn, Chapel Hill

Sponsors: Department of Obstetrics and Gynecology and the Office of Continuing Education, UNC School of Medicine; Office of Continuing Education, UNC School of Nursing

Fee: \$50; James M. Johnston Awards available

Credit for physicians: 11 hours; AAFP approved

Recognition for nurses: 11 contact hours; NCSNA CERP

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514, or Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 12-16

The Nursing Process

Fee: \$112; James M. Johnston Awards available

Recognition: 28 contact hours; NCSNA CERP

For Information: Judith E. Wray, Administrative Secretary, Continuing Education Program, UNC School of Nursing, Chapel Hill 27514

May 13-14

Breath of Spring, '75—Respiratory Care Symposium

Place: Babcock Auditorium

Sponsors: Northwestern Lung Association; Division of Continuing Education, Bowman Gray School of Medicine

Fee: \$25

Credit: 12 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 22-24

Successful Treatment of the Elderly Mentally Ill

Sponsor: Older Americans Resources and Services Program of the Center for the Study of Aging and Human Development

Program: Designed for psychiatrists, internists, family practitioners, nurses, social workers, psychologists and pastoral counselors, in relation to their work with older patients

For Information: Dorothy Heyman, Box 3003, Duke University Medical Center, Durham 27710

May 23

Perinatology Postgraduate Course

Place: 103 Berryhill Hall

Sponsors: Department of Pediatrics; Office of Continuing Education

Registration: pre-registration requested

Credit: 6 hours; AAFP credit applied for

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 23-24

Pediatric Neurology

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 28-29

26th Annual Scientific Sessions of the North Carolina Heart Association

Place: Winston-Salem Hyatt House and Convention Center

Fee: Physicians and Medical Scientists, \$20; Others, \$10, except no fee for students, interns and residents. Registra-

tion fee includes cost of banquet and breakfast.
 Credit: 5 Hours; AAFP credit applied for
 Note: Special sessions will be held for cardiology technologists, emergency medical personnel, technologists and for volunteers
 For Information: Norris B. Harbold, M.D., North Carolina Heart Association, P. O. Box 2408, Chapel Hill 27514

June 3-5

Rehabilitation of the Patient with Myocardial Infarction—
 An Interdisciplinary Approach
 Place: Carrington Hall
 Sponsors: Continuing Education, UNC School of Nursing; Division of Physical Therapy, Department of Medical Allied Health Professions, UNC School of Medicine; North Carolina Heart Association
 Fee: Registration \$15
 For Information: Barry R. Howes, Assistant Professor, Department Medical Allied Health Profession, UNC School of Medicine, Chapel Hill 27514

June 20-22

New Advances in Diagnosis and Treatment of Pediatric Pulmonary Diseases
 Place: Quail Roost Conference Center, Creedmoor
 Registration: limited to 40 pediatricians, internists or family practitioners
 Credit: 11 hours; AAFP approved
 For Information: Alexander Spock, M.D., P. O. Box 2994, Duke University Medical Center, Durham 27710

July 14-19

Duke Medical Postgraduate Course
 Place: Atlantis Lodge, Atlantic Beach
 Fee: \$125
 Credit: 30 hours; AAFP credit applied for
 For Information: William J. DeMaria, M.D., Assistant Dean, Office of Continuing Medical Education, Duke University Medical Center, Durham 27710

July 21-26

Postgraduate Course in Radiology
 Place: Atlantis Lodge, Atlantic Beach (near Morehead City)
 Fee: \$150; designed for radiologists, but open to all physicians. Enrollment limited to 75
 Credit: 30 hours
 For Information: Robert McLelland, M.D., Department of Radiology, P. O. Box 3808, Duke University Medical Center, Durham 27710

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop
 Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
 Sponsors: Divisions of Continuing Education, Bowman Gray, Duke, and UNC Schools of Medicine, and the Medical College of South Carolina
 Fee: \$100
 Credit: 20 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 5-6

North Carolina Chapter of the American Academy of Pediatrics and the North Carolina Pediatric Society—Annual Meeting
 Place: Blockade Runner, Wrightsville Beach
 For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 12-13

North Carolina Association of Blood Bankers Annual Convention
 Place: Sheraton Inn, Charlotte
 For Information: Roy A. Weaver, M.D., President, P. O. Box 2000, Cape Fear Valley Hospital, Fayetteville 28302

September 12-14

Legislative Workshop: this institute will bring together members of the North Carolina Medical Society and persons from the legislative and executive branches of North



Pro-Banthine®

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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Address medical inquiries to: G. D. Searle & Co., Medical Department, Box 5110, Chicago, Ill. 60680 481

Carolina state government, so that North Carolina physicians may gain a better understanding of the process of government.

Place: Center for Continuing Education, Appalachian State University, Boone

Sponsors: North Carolina Medical Society and Smith Kline & French Laboratories

For Information: Stephen C. Morrisette, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter, American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital

Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children.

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists—Annual Conference

Place: Benton Convention Center, Winston-Salem

Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education, scientific exhibits and a display of commercial equipment.

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

OTHER ITEMS OF INTEREST

Continuing Education in Western North Carolina

For Information about the following programs, contact the Health Education Commission of Western North Carolina, P. O. Box 7607, Asheville 28807, or the information source indicated for the respective program:

April 10—Care of the Aging

Place: C. J. Harris Hospital, Sylva

Information: WCU Department of Nursing

April 11—Care of the Aging

Place: Rodeway Inn, Asheville

Information: WCU Department of Nursing

April 11—Clinical Laboratory Safety

Place: American Red Cross Building, Asheville

April 25—Cancer Workshop

Place: Lambuth Inn, Lake Junaluska, Waynesville

Information: WCU Department of Nursing

April 28—Pediatric Emergencies

Place: Transylvania Community Hospital, Brevard

April 29—Pediatric Emergencies

Place: John C. Campbell Folk School, Brass-town

April 30—Nursing Home Workshop

Seminars in Cardiology

March 18—Management of Arrhythmias Complicating Acute Myocardial Infarction

April 15—Recognition and Management of Complications Following Acute Myocardial Infarction

May 20—Rehabilitation Following Myocardial Infarction

June 17—Exercise Testing

Place: C. J. Harris Hospital, Sylva

Program: Physicians who will be in attendance are encouraged to refer any of their patients who present unusual treatment problems. During the morning, patients will be seen by a consulting cardiologist from the UNC or Bowman Gray School of Medicine, and by other physicians. The first part of the afternoon will consist of case presentations and a lecture pertaining to the specific disease entity on which the respective seminar is focused. The last part of each seminar afternoon will consist

of a lecture and demonstration in Electrocardiography. Sponsors: Jackson County Medical Society; Health Education Commission of Western North Carolina

Credit: AAFP credit applied for

For Information: Ralph S. Morgan, M.D., Box 668, Sylva 28779

Continuing Education via Satellite

The following programs are scheduled to be received from the ATS-6 communications satellite, by the veterans' hospitals at Fayetteville, Oteen and Salisbury on the dates indicated. Sessions are open to all physicians and other interested health professionals.

April 16—1 p.m. Genital Urinary Infection
2 p.m. Drug Abuse Rehabilitation

April 23—1 p.m. Inhalation Therapy

2 p.m. Intractable Angina

April 30—1 p.m. Solitary Pulmonary Nodule

2 p.m. Depression

May 7—1 p.m. Suicidal Patient

2 p.m. Drug Abuse Rehabilitation

May 14—1 p.m. Cardiac Catheterization

2 p.m. Ultrasonics in Cardiology

May 21—1 p.m. POMR Update

May 28—1 p.m. Use of Satellites in Biomedical Communications

As this schedule has been subject to some change in the past, it might be advisable to check with one of the following before attending:

Fayetteville—Mr. Kenneth Gath (488-2120)

Oteen—Stewart Scott, M.D. or Mary Ellen Lutz, R.N. (298-7911)

Salisbury—Mr. Dante Spagnolo (636-2351)

Nursing Equivalency Exams Available

The North Carolina Nursing Equivalency Examinations, "designed to give licensed practical nurses and other individuals an opportunity to get college credit toward the first year's work in an Associate Degree (ADN) Program," are now available at six College-level Examination Program test centers in North Carolina.

To apply, contact one of the following: Dr. D. W. Proctor, Dir. of Guidance, Gardner-Webb College, Boiling Springs 28017; Mrs. J. G. Bailey, Dir. of Testing, East Residence Hall, ASU, Boone 28607; Dr. R. B. Simono, Dir., Counseling Center, UNC, Charlotte 28202; Dr. L. M. McManus Jr., Dir., Counseling Center, Fayetteville State University, Fayetteville 28301; Miss E. Saunders, Dir., Guidance & Placement, Methodist College, Fayetteville 28301; Mr. R. K. White, Counselor, NCSU, Box 5505, 210 Peele Hall, Raleigh 27607.

Developed by the North Carolina Regional Medical Program in cooperation with the College Entrance Examination Board and Educational Testing Service, the examinations were made possible by grants from the United States Public Health Service and the Kate B. Reynolds Health Care Trust.

For an informational booklet of descriptions, sample questions and score information, contact: College Board Publications Orders, Box 2815, Princeton, New Jersey 08540

PROGRAMS IN CONTIGUOUS STATES

April 25

The Psychiatric Problems of Coal Miners—A Seminar

For Information: Mr. George K. White, Administrator, Saint Albans Psychiatric Hospital, Radford, Virginia 24141

April 26-30

International Biomaterials Symposium

Sponsors: Clemson University and the National Institute for Dental Research

Fee: \$150

For Information: Professor J. K. Johnson, Continuing Engineering Education, 116 Riggs Hall, Clemson University, Clemson, S. C. 29631

May 12-15

Cardiology for the Internist

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: American College of Cardiology; Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of

Medicine, Atlanta, in cooperation with Georgia Heart Association
For Information: Miss Mary Anne McNerny, Director,
Department of Continuing Education Programs, American
College of Cardiology, 9650 Rockville Pike, Bethesda,
Maryland 20014

Items submitted for listing should be sent to: WHAT?
WHEN? WHERE? P. O. Box 8248, Durham, N. C. 27704,
by the 10th of the month prior to the month in which they
are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

HEALTH CARE POWER

"Why," asked Miss Bess Myerson of Dr. Knowles, a distinguished physician and president of the Rockefeller Foundation, "doesn't organized medicine take a more active role in eliminating or reducing health hazards in this country? . . . Shouldn't health care begin long before the specific condition that brings us to the doctor's office?"

"Absolutely," he said. "I happen to believe that the doctor has untapped power in his community to influence action—more power than anybody else. . . . I think he has been derelict in meeting his responsibilities." (Interview, *Redbook*, March 1975.) (Miss Myerson and Dr. Knowles are members of the National Commission on Critical Choices for Americans.)

Despite this negative view, the Woman's Auxiliary to the American Medical Association (AMA) has *tapped power*. Its members, dedicated to improving the health of the nation, have proved themselves to be real helpmeets through projects and health education, shouldering responsibilities to the community which otherwise would be borne by physicians. In an address to the house of delegates at the 1974 AMA clinical convention in Portland, Oregon, the national president of the Woman's Auxiliary to the AMA, Mrs. Howard Liljestrand, sought to explain the power and purpose of the auxiliary:

"If the wife takes her auxiliary membership seriously, she not only brings credit to medicine through service projects, but because of being informed she says the right thing in her many conversations with the public. This is good for the medical profession, and is one reason that it is important for our two organizations to work closely together, as in the scientific sessions at this meeting, designed for both husbands and wives.

"Doctors' wives are interested in the welfare of medicine because of the unique manner in which they became eligible. There's only one way to get into our organization. Each one of us was handpicked by a doctor. Each of us thinks that doctor is great and we want the community to think so, too. So we

appreciate knowing how to answer the bus driver, the butcher, and the baker, who are getting plenty of misinformation about doctors from labor publications. Through knowing how to answer questions in our person-to-person contacts, we bring credit to you. . . .

"Another side benefit, which is real, is what the auxiliary does for the doctor's wife by providing the opportunity for constructive self-expression. . . .

"We're really not just messing around. You don't raise a million dollars [for AMA-ERF] by drinking coffee.

"Your 180,000 members must have more than 90,000 wives. Maybe you can help us correct this high discrepancy. No wife is going to join if her husband is not enthusiastic. We know of counties which are unorganized because the doctors want it that way. We're surprised at that attitude. We cringe when the press maligns you, for we know how great you are, even without the Harris poll, which again has placed you first in the nation, most trusted by the public. We're mighty proud to be married to you."
—(from *M.D.'s Wife*, March 1975.)

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

President Ford has named Dr. Ewald W. Busse to a six-member biomedical research commission to study research financing and priorities for research, with special emphasis on behavioral research funding, in the Department of Health, Education and Welfare (HEW). The White House panel was created by Congress following discontent within the National Institutes of Health (NIH) about research funding and the executive branch's firing of the last two NIH directors. The panel was sworn in by Vice President Rockefeller, and a report from the commission to the President is expected in 15 months.

Busse is associate provost and director of medical and allied health education. For 20 years he was chairman of the Department of Psychiatry and he is a past president of the American Psychiatric Association.

* * *

Two researchers at the medical center have been awarded March of Dimes grants totaling \$30,986 for one year under a unique program designed to enable young scientists to start their own research projects in birth defects. They are among 57 United States investigators awarded Basil O'Connor Starter Research grants, totaling \$990,647, named in honor of the man who led the National Foundation-March of Dimes from its inception in 1938 until his death in 1972.

Dr. Edward W. Holmes, assistant professor of medicine, will analyze the molecular structure and

properties of a human enzyme, PRPP aminotransferase, which plays a key role in the life cycle of cells. Genetic or environmental factors which interfere with the enzyme may be involved in various birth defects, of which the causes are not known. In a separate project, Dr. Allen D. Roses, assistant professor of medicine (neurology), will explore cell membrane characteristics in cells of patients with myotonic dystrophy, an inherited, slow deterioration of the heart and other muscles, mental capacity, vision and glandular functions.

* * *

Surgeons here have successfully transplanted two parathyroid glands from a father to his 19-year-old son. It is believed to be the first transfer of parathyroids from one living patient to another. Dr. Samuel A. Wells, Jr., an associate professor of surgery, said he and his colleagues transplanted the glands a year-and-a-half ago and have been following the patients closely since. Both have recovered with no ill effects, and the boy's immune system has not rejected his new glands.

* * *

Dr. Lillian R. Blackmon, assistant professor of pediatrics, attended a meeting in Columbus, Ohio, to participate in the organizing of a national association of health care professionals interested in the delivery of perinatal health care. She attended as a representative of the Southern Perinatal Association, an organization in which she has served as secretary-treasurer since its founding in 1973.

* * *

Recent medical faculty promotions and appointments are: Drs. Shirley K. Osterhout, promoted to assistant professor of pediatrics; Joseph C. Farmer, Jr., promoted to associate professor of otolaryngology; Dorothy E. Naumann, promoted to assistant professor of community health sciences and administrative director of the Student Health Service; John W. Reed, promoted to associate professor of ophthalmology; M. Bruce Shields, promoted to assistant professor of ophthalmology; Walter G. Wolfe, promoted to associate professor of surgery; Robert F. Wilfong, appointed assistant professor of neurosurgery; and Donald S. Bright, appointed assistant professor of orthopaedic surgery.

* * *

The National Cancer Institute has announced grants to two medical center scientists who are conducting clinical and basic science research on malignant tumors. The awards will total almost \$240,000 over the next three years.

Dr. Nelson L. Levy, assistant professor of immunology, will receive \$182,440 to support his studies of the body's immune response to tumor growth, and Dr. F. Stanley Porter, professor of pediatrics, has been awarded \$56,531 to finance his participation in the activities of the Southwestern Oncology Group.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

An exhibit on "Familial Polyposis," prepared at the Bowman Gray School of Medicine, has won a first-place award at the Southeastern Surgical Congress meeting in Atlanta. It also took a first-place award last November during the 68th annual scientific meeting of the Southern Medical Association.

The exhibit was prepared by Dr. Howard G. Dawkins, resident in surgery; Dr. Thomas Vargish, resident in surgery; Dr. Thomas F. O'Brien, associate professor of medicine; and Dr. Richard T. Myers, professor and chairman of the Department of Surgery.

* * *

A film prepared by the Department of Pediatrics was featured recently on a UNC-TV Network program. Childhood cancer was the program's topic.

The film, entitled, "The Can in Childhood Cancer" was produced by the medical school's Audiovisual Department and was sponsored by the North Caro-

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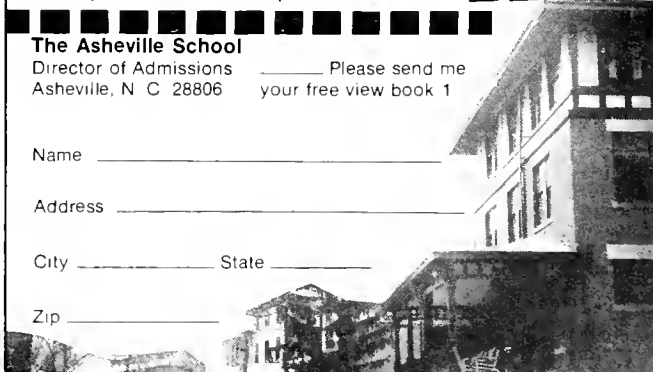
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lina Regional Medical Program. It featured Dr. Richard B. Patterson, associate professor of pediatrics, and Mrs. Deborah Burchette, a pediatric oncology associate. Both were joined on the program's question and answer panel by Dr. Carolyn Ferree, instructor in radiation therapy.

* * *

Dr. Bill C. Bullock (D.V.M.), associate professor of comparative medicine, has been named vice chairman of the American Association for Accreditation of Laboratory Animal Care.

* * *

Clyde T. Hardy, Jr., associate dean for patient services, has been appointed to the Accrediting Commission on Graduate Education for Hospital Administration, the accrediting and reviewing agency for all the graduate schools of hospital administration in the nation.

* * *

Dr. Donald M. Hayes, professor and chairman of the Department of Community Medicine; Dr. Henry W. Johnson, clinical assistant professor of pediatrics; and Dr. James F. Toole, professor and chairman of the Department of Neurology, were honored recently by the Forsyth Health Planning Council for their work as directors of the council.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, has been appointed a member of the finance committee of the American College of Psychiatrists.

* * *

Dr. Alfred J. Rufty, assistant professor of medicine, has been elected to a three-year term on the board of directors of the North Carolina Heart Association. He also serves as chairman of the association's Hypertensive Work Group.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

A three-year, \$502,819 study, sponsored by the National Institute of Child Health and Human Development, DHEW, will be initiated at the Frank Porter Graham Child Development Center (FPG) in Chapel Hill to find out what can be done for babies during their first year of life to better prepare them for their school years.

Dr. Craig Ramey, who will direct the research, said the FPG Program Project will design a unique "infant curriculum" that can be used by parents or day care workers to prompt the development of a baby's first abilities. One-hundred twelve children will be chosen from low-income families in the Chapel Hill area before they are born. Selection will be based on parent interviews and medical records.

Rondomycin® (methacycline HCl)

CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See **WARNINGS**.)

Renal toxicity: rise in BUN, apparently dose related. (See **WARNINGS**.)

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5-4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: "Rondomycin" (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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Dr. Philip Francis Hirsch has been appointed director of the Dental Research Center, UNC-Chapel Hill, effective May 1, 1975. He succeeds Dr. Andrew D. Dixon who resigned the post to become dean of the School of Dentistry at the Center for Health Sciences, University of California at Los Angeles. Dr. Gary Smiley has been acting director since July 1973, and will continue as associate dean and assistant director of the center.

The center, established in 1967 to promote better oral health through teaching and superior research in a multi-disciplinary program that reaches into national and international areas, is sponsored by the National Institute of Dental Research.

For the past four years, Dr. Hirsch has been a professor of pharmacology in the School of Medicine, and since 1968 he has been director of the UNC Graduate Training Program in Pharmacology.

* * *

Aldo Rustioni was appointed associate professor of anatomy and physiology in the School of Medicine. He has been a visiting associate professor at the University since 1973. He received the M.D. from Parma Medical School in Italy.

* * *

Promoted to assistant professor in the School of Medicine are: Margaret A. Cook, Department of Physiology, and Jean R. Reiner, Division of Physical Therapy, Department of Medical Allied Health Professions.

* * *

The School of Pharmacy at UNC-Chapel Hill has been awarded a \$12,868 grant from the National Institute of Arthritis and Metabolic Diseases. The grant supports research dealing with alkoxy and alkenyloxy glyceryl ethers and derivatives. Dr. Claude Piantadosi, head, division of medicinal chemistry, is principal investigator.

* * *

In the School of Public Health, UNC-Chapel Hill, Harriet H. Barr has been promoted to assistant professor, Department of Health Administration.

* * *

Charles E. Lawrence was named associate professor in the Department of Health Administration. An assistant professor at Rensselaer Polytechnic Institute since 1971, he holds the B.S. from Rensselaer and the Ph.D. from Cornell University.

* * *

The Department of Environmental Sciences and Engineering, School of Public Health, received a \$6,000 grant from DuPont Company to support research and teaching.

ALLERGY AND IMMUNOLOGY FOR THE PRACTICING PHYSICIAN

A postgraduate course sponsored by the Department of Pediatrics and Child Health, Howard University, Washington, D. C., will be held June 19-21,

1975. The basic knowledge of and recent advances in allergy and clinical immunology will be presented, and common allergic and difficult-to-manage disorders seen in private practice will be discussed. The fee is \$70.

For further information write: M. Ali Abrishami, M.D., Director, Pediatric Allergy Program, Department of Pediatrics, Howard University, Washington, D. C. 20060.

AMERICAN BOARD OF FAMILY PRACTICE (ABFP)

The American Board of Family Practice, the certifying body in the specialty of family practice, named new officers and directors at their January annual meeting: Officers: President—George Burket, Jr., M.D., Kansas City, Kan.; Vice President—Neil Chisholm, M.D., Denver, Colo.; Secretary—Nicholas J. Pisacano, M.D., Lexington, Ky. (re-named); Treasurer—Amos Johnson, M.D., Garland, N. C. (re-elected); Directors—James G. Price, M.D., Brush, Colo. (from the AAFP); Charles Strong, M.D., Vancouver, Wash. (from AMA Section on Family/General Practice); Shervert Frazier, Jr., M.D., Belmont, Mass. (from the ABPN).

Because family practice embraces other disciplines, its certifying board is unique in that five of its members represent these other related specialty boards: Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, and Psychiatry and Neurology.

The Board's primary role is to set standards and provide and administer a certifying examination in the specialty. Five such examinations have been held and more than 7,000 physicians have been certified. Those passing the two-day examination are called "diplomates," who must be recertified every six years. The specialty of family practice is the only one requiring recertification.

NORTH CAROLINA REGIONAL PERINATAL HEALTH CARE PROGRAM

In January 1974, a Task Force on Maternal and Infant Care submitted its report to the Governor's Advisory Council on Comprehensive Health Planning, citing high perinatal mortality and morbidity rates in North Carolina and outlining contributing factors. Corrective measures recommended were: (a) Improved community perinatal health care services with emphasis on education, increased prenatal care, identification of high-risk mothers, interconceptional care, transportation and communication, (b) Improved hospital services and the establishment of hospital centers at three levels: Community Centers to provide care for normal mothers and infants and those with complications most suitably managed in that center; District Centers to deal with complicated perinatal problems; and Regional Centers to refer complex perinatal problems; and (c) Development of regionalized organization of services to coordinate regional community services and hospitals at all

three levels to assure that each mother and infant receive appropriate care, as well as intra-regional cooperation for education, consultation, referral, transportation, and evaluation; and (3) State financial support for hospital renovation and equipment, personnel, subsidization of patient care, administration and evaluation.

The Advisory Council has recommended that the initial efforts of the program be directed toward implementation of the Regional Perinatal Health Care Program, as a pilot project, in an area with a high perinatal mortality rate. It recommended funding a project in Robeson, Scotland, Hoke, Bladen, and Columbus counties. Two Community Centers (Scotland Memorial and Columbus County) and one District Center (Southeastern General) will participate in the program with Duke University Medical Center, Durham, and the North Carolina Memorial Hospital, Chapel Hill.

A copy of the Task Force Report and additional information may be obtained by writing to: Dr.

Richard Nugent, Department of Human Resources, P.O. Box 2091, Raleigh, N. C. 27602 (919-829-2815).

RETRAINING PROGRAM FOR INACTIVE PHYSICIANS

The Medical College of Pennsylvania will hold a session of the Retraining Program for Inactive Physicians from May 5 through June 20, 1975. Thereafter, the program will be held twice yearly for at least the next two years. The application deadline for the fall 1975 program is September 1, 1975. Clinical training for inactive physicians who wish to re-enter clinical medicine by offering review of physical diagnostic skills, clinical rotations, and a lecture series on general medicine, pathophysiology, diagnosis and patient management will be provided.

For an application and additional information, contact: Retraining Program, Center for Women in Medicine, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pa. 19129.



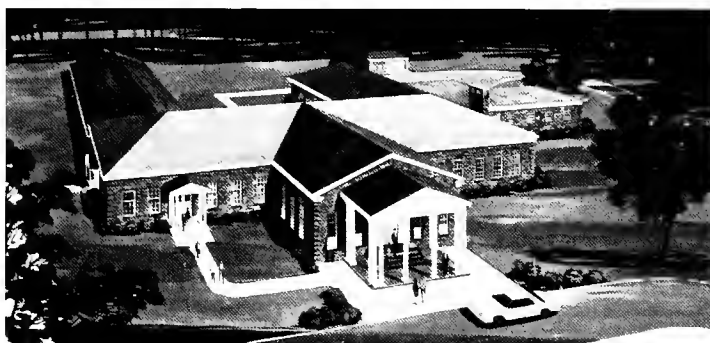
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The American Medical Association (AMA) has submitted to the 94th Congress a new proposal for national health insurance (NHI), the only major proposal to have been substantially revised from previous offerings. It is designed to provide full health care for all (except Medicare beneficiaries) through private health insurance including catastrophic illness protection. The principal features are: (1) mandated employer coverage, (2) coverage for the self-employed and unemployed with a subsidy for premium costs for those self-employed with low incomes, and (3) supplemental coverage and subsidized premium for Medicare beneficiaries in order to equalize benefits. The major difference between the mandated plan and the Mediredit bill endorsed by the AMA in the last Congress is that the bulk of government financing relies on general revenues rather than on tax credits, although the tax credit principle is retained for the self-employed.

Despite the 186 sponsors that backed the AMA's Mediredit plan last year—the largest body of support for any NHI measure including that of labor—considerable Congressional resistance developed to tax credits as a financing base. Under the revised AMA proposal, most people would receive health care protection under a mandated employer program fully financed by premiums paid by employers and their employees. Participation would be optional for employees and at least 65 percent of the premium would be payable by the employer.

The former Mediredit principles would apply to insurance for the jobless and the self-employed. The individual or family would buy "qualified health care insurance," that which meets federally established standards of benefits and policy conditions, and for those whose income falls within a defined subsidy level, the federal government would contribute toward the cost of the premium on a scale related to income.

Government contributions to premiums would be in the form of a credit against income tax or a certificate of entitlement issued by the government and acceptable by the insurer for payment of premium. An individual or family subsidy in any year would be based on its income (measured by income tax liability) for the preceding year. Limited income individuals or families having no tax liability would be entitled to a tax credit (or certificate) for the full amount of the insurance premium. For other

eligible persons the entitlement would range from ten percent to 99 percent of the premium.

Non-employed Medicare beneficiaries would be eligible for federal subsidy for premiums for "qualified supplemental coverage" designed to equalize the available benefits for the elderly as for all others. Such supplemental insurance would be the same as the full insurance policy for persons under 65, but would contain a clause for exclusion of all benefits obtainable under Parts A and B of Medicare. It would not cover deductibles and coinsurance under Medicare, but would require no deductible or coinsurance payments for the supplemental benefits. The plan provides for continuation of an employee's insurance following termination of employment and would be fully paid from a special fund created from general revenues to cover periods of unemployment.

The catastrophic coverage provision requires no deductible. Coinsurance would apply at a rate of 20 percent on the cost of all covered benefits, within a ceiling limit. The poor would pay no coinsurance, and for others, the coinsurance maximum would be ten percent of the individual or family income, reduced by an "exclusion base," the amount of which would vary according to family size, and would be set at \$4,200 for a family of four. Thus a family of four earning \$15,000 would have a coinsurance limit of ten percent of \$10,800 (\$15,000 less \$4,200), or \$1,080. In no case, however, could coinsurance for a year exceed \$1,500 for an individual or \$2,000 for a family. The ceiling on coinsurance would trigger catastrophic expense protection. All benefits under the insurance policy would thereafter continue for the remainder of the policy with no further obligation for coinsurance.

Some special provisions are that:

(1) Employers whose payroll costs are increased by more than three percent as a result of purchasing mandated coverage for employees would receive a cash (or tax credit) subsidy—80 percent of the excess cost in the first year, continuing on a descending scale for four years following.

(2) Employers who failed to comply with the mandate would be liable for reimbursement to employees for expenses incurred by reason of the employer's noncompliance, and subject to a fine of up to two times what the employer would have spent in compliance.

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(3) For the unemployed and the self-employed, the maximum premium would be 125 percent of the average per employee premium for all large group employees in the state.

(4) An assigned risk pool would be established in each state. All carriers in the state would participate and would accept risk assigned to it.

(5) The federal government would be prohibited from interfering with the practice of medicine.

(6) Physician services would be reimbursable at "usual and customary, or reasonable charges." Hospital services payments would be determined by a state agency, after consultation with providers, on a "reasonable cost basis" under acceptable methods of reimbursement including appropriate prospective rate determination systems. Other costs would be paid on a reasonable charge or a reasonable cost basis, as appropriate.

As with the earlier Medigap plan, the medical profession's new proposal would replace Medicaid.

* * *

Despite loud barks to the contrary from Democrats of both House and Senate leadership, the chances of passage of any type of national health insurance (NHI) measure this year or next year seem remote. Such landmark legislation is more likely to come about in the 95th Congress due to the ever-growing restraints on the present economy.

Nonetheless, the House Ways and Means Committee's new subcommittee on Health (Dan Rostenkowski, Chairman, D-Ill.) has named an advisory panel on NHI. The list numbers more than 100 names—with more to come—and draws heavily from academia. Plans are to study updated legislative recommendations of interested groups through April 15 and then hold, few if any, public hearings on NHI before framing a bill. The advisory group has no members who are officials of national organizations or groups that have espoused specific approaches to NHI, but rather those who "know something that the Subcommittee should learn about and were not chosen to represent organized interests," said Rostenkowski.

* * *

The present crisis in the underwriting of professional liability insurance has become a key issue in the new Congress. The Senate Health Subcommittee slated hearings starting in April and the House Health Subcommittee was expected to follow suit. Five major bills already have been introduced. However, a ticklish jurisdictional problem has cropped up, with no one sure yet what Congressional committee should have prime legislative responsibility. Technically, it would appear that the House and Senate Judiciary committees would have a strong claim because of the legal aspects of the problem. However, the Health subcommittees as well as House Ways and Means and Senate Finance also have an obvious stake.

Principal professional liability bills already intro-

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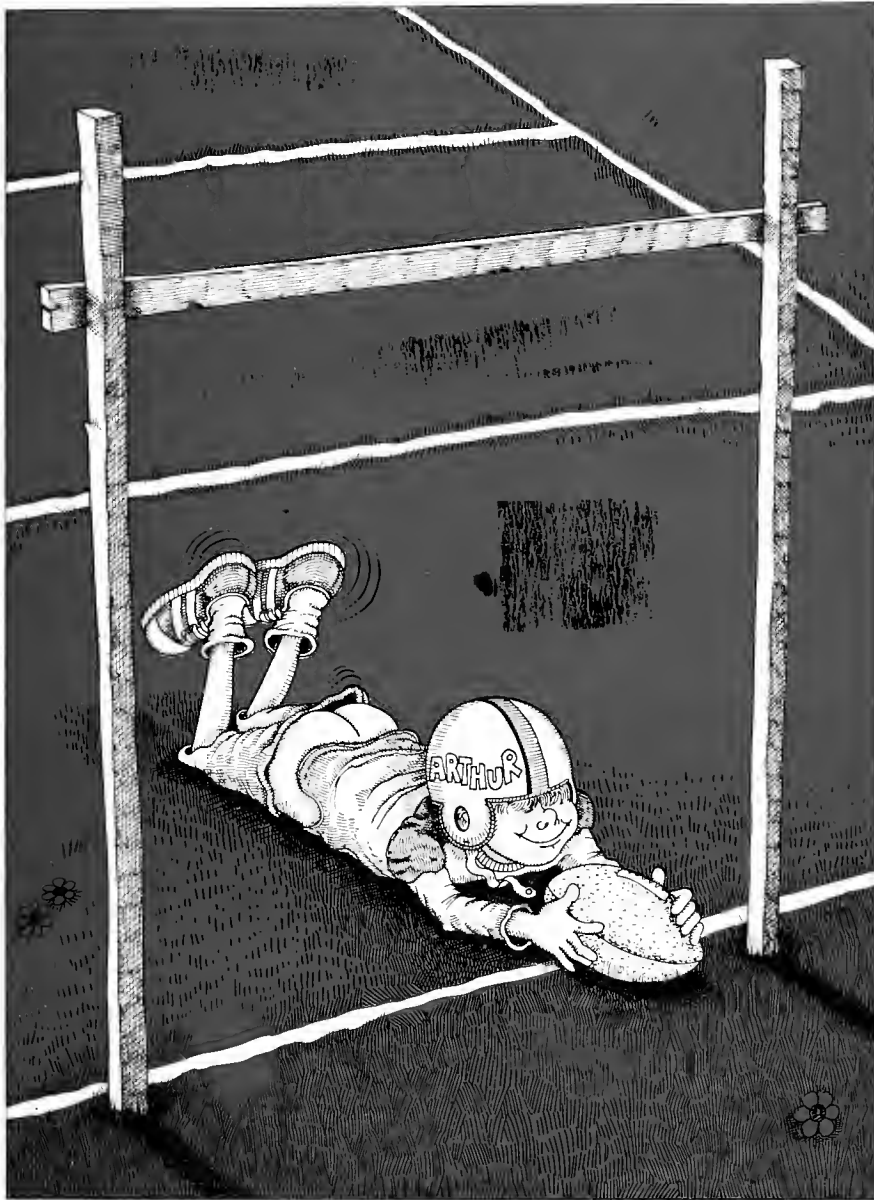
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duced include: H.R. 1305, by Representative Marjorie Holt (R-Md.), to establish a Commission on Awards; H.R. 1378, by Chairman Dan Rostenkowski (D-Ill.), Ways and Means Health subcommittee, to provide for studies of the problem by the National Academy of Science's Institute of Medicine; S. 188, by Senator Gaylord Nelson (D-Wis.), to authorize HEW to set up a reinsurance program and to conduct studies and experiments; S. 482, by Senators Ted Kennedy and Daniel Inouye (D-Hawaii), for a no-fault plan eliminating contingency fees but subjecting physicians to strict supervision; S. 215, by the same Senators, to establish compulsory arbitration as an alternative to the above proposal.

The American Hospital Association (AHA) has voted for the creation of a captive reinsurance company, or comparable mechanism, to implement a national malpractice and general liability insurance program for hospitals and a positive legislative program to seek remedies. A one-time assessment of \$4 per hospital bed would help start the plan, which wouldn't be acted upon until a special meeting in May.

The AHA plan would provide first dollar coverage up to the limit of the policy purchased by the hospitals, to provide coverage for every malpractice occurrence of up to \$15 million. All employees of the hospital including house staff would be covered. Physicians under contractual compensation relationships would be included. However, AHA said the insurers

have advised that private practitioners cannot be included at this time in this program.

Rep. James Hastings (R-N. Y.), a member of the House Health Subcommittee, announced that a national conference on medical malpractice insurance would be held in late March in Washington, an attempt to examine the causes of the malpractice crisis and explore all alternatives for developing a workable remedy which would protect both the doctor and his patient. The two-day conference was arranged by Hastings and the American Group Practice Association.

* * *

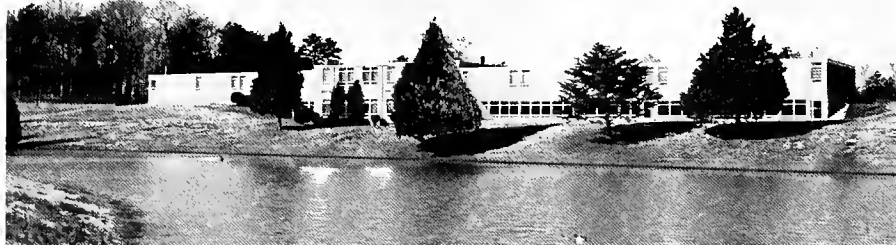
Ten patients and five physicians have joined the AMA in legal action against new hospital utilization review regulations adopted by the Department of HEW. The action marks the first time the AMA has taken court action against the government. The suit, filed in Northern Illinois Federal District Court, seeks a preliminary injunction, on the grounds that the plaintiffs will be "irreparably injured" if the regulations are permitted to remain in force. Ultimately, a permanent injunction is requested.

The AMA and its co-plaintiffs contend that the utilization review regulations: violate the constitutionally protected rights of patients to receive medical care in accordance with the best judgment of their doctors, the constitutionally protected rights of physicians to practice medicine, and specific sections of the Medicare and Medicaid laws; exceed the authority

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granted to the Secretary of HEW; and were issued in a manner contrary to the procedures required by the Constitution and the Administrative Procedure Act.

The regulations, effective February 1, gave hospitals until April 1 to file with state agencies their plans for implementing the regulations. They require that every decision by a physician to hospitalize a Medicare or Medicaid patient be evaluated by a utilization review committee of the admitting hospital within one working day of the patient's admission.

The Committee may have members who are not physicians and may act through agents who are not physicians. "This is the issue we are putting before the courts and before the American people," stated AMA President Malcolm C. Todd, M.D. "Is the decision that you need hospital care to be made by your doctor, who knows you, or by a physician who does not know you—or worse yet, by a non-physician. The issue is that simple," Dr. Todd said.

* * *

Congress has signaled for flank-speed on anti-

recession legislation to provide health insurance to the unemployed. Hearings have been slated by the Health Subcommittee of the House Ways and Means Committee. The Senate Health Subcommittee will also conduct hearings. Major bills have been introduced in both House and Senate to ease the problems of the growing number of the out-of-work by helping them obtain private health insurance in those cases where it has lapsed because of unemployment.

The AMA has proposed such assistance and urged the lawmakers to approve it. The bill contains the following concepts:

(1) Employers who provide health insurance for employees would be required to continue coverage for 30 days after an employee's termination.

(2) An unemployed person's working spouse would immediately be eligible to enroll in a health insurance plan, even if the plan were not open to enrollment otherwise.

(3) Other unemployed persons eligible for unemployment compensation would be continued in the plan at their last place of employment with premiums paid by the federal government from general revenues.

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Book Review

Cardiac Arrest & Resuscitation. 4th edition. By Hugh E. Stephenson, Jr., M.D. 998 pages. Price, \$45.50. St. Louis, Missouri, C. V. Mosby Co., 1974.

This voluminous (998 pages), comprehensive review of cardiac arrest and resuscitation is significantly more inclusive than the first edition of 378 pages. It could be otherwise entitled, "What Anyone Would Ever Want to Know about Cardiac Arrest and Resuscitation or Anything Related to Cardiac Arrest and Resuscitation."

The publication is divided into broad, functional sections. The section on detection and avoidance of potential factors contributing to cardiac arrest, and the subsequent section on mechanisms of cardiac arrest, particularly well researched and written, should be of interest to anesthesiologists in preoperative evaluation or during an operation. The eloquent discussion of pathophysiology should be of value to generalists, internists and cardiologists.

Two-hundred pages are devoted to the techniques of cardiopulmonary resuscitation. Some of the little known improvements in resuscitation technique are discussed, photographs of new types of equipment are offered, and helpful recommendations regarding cardiac pacing and other special techniques are described. This section and the one on pharma-

cology should be particularly useful in the formative stages of a hospital cardiopulmonary resuscitation program.

The section on the extension of cardiopulmonary resuscitation techniques outside the hospital (such as the use of mobile coronary care ambulances as originally described by Pantridge and Geddes) also describes the mechanism and results of the establishment of resuscitation capability in crowded areas—football games and industrial buildings. Although such data have been previously reported by the Inter-Society Commission for Heart Disease Resources, the information in this publication has been well compiled and summarized. The informative, authoritative sections on post-resuscitation care and medical-legal aspects of cardiopulmonary resuscitation provide excellent resource information.

The book provides more information than the average practitioner needs at his disposal for emergency cardiopulmonary resuscitation, but it can be valuable as a resource book for physicians and committees establishing protocols for cardiopulmonary resuscitation either inside or outside medical institutions. Cardiologists, anesthesiologists and internists should find the discussions of risk factors and mechanisms in cardiac arrest helpful.

ROBERT N. HEADLEY, M.D.

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Small Bowel Intramural Hematoma Secondary to Coumadin® Anticoagulation, Thomas M. Daniel, M.D., Robert H. Jones, M.D., Thomas M. Dryer, M.D., R. Scott Jones, M.D., and R. W. Postlethwait, M.D.; Follow-Up Study of Patients Discharged from an Alcohol Rehabilitation Center, Mary Castle, M.P.H., and Joan C. Cornoni, M.P.H., Ph.D.; To a Louse, H. A. Matthews, M.D.

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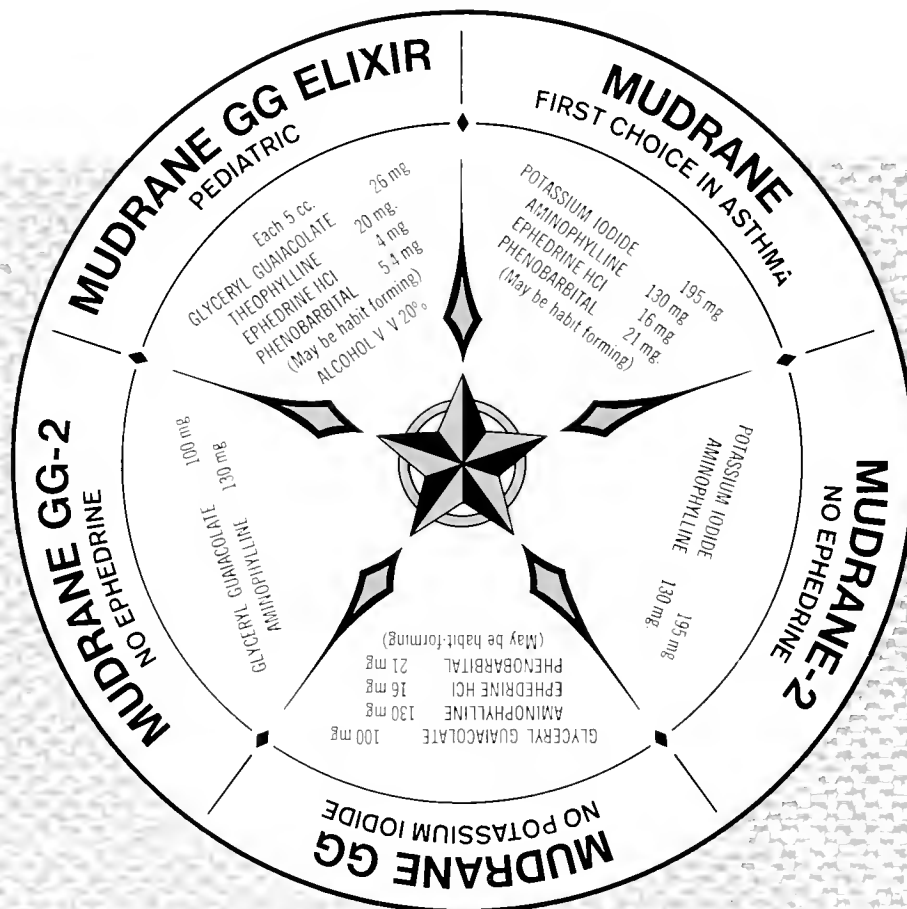
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Small Bowel Intramural Hematoma Secondary to Coumadin® Anticoagulation

Thomas M. Daniel, M.D., Robert H. Jones, M.D., Thomas M. Dryer, M.D.,
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SINCE the introduction of anticoagulation therapy using Vitamin K antagonists in 1941,¹ numerous complications have been observed in patients receiving these agents. Approximately ten percent of hospitalized patients receiving oral anticoagulants, and nearly 40 percent of anticoagulated outpatients, have had minute to fatal hemorrhage — usually hematuria, ecchymosis, epistaxis, bleeding gums, hemoptysis and hematoma.² Bleeding into the skin³ and breast⁴ with necrosis, and into the subdural space, eyeball, pericardial sac, retroperitoneal area, kidney,⁵ rectus sheath,⁵ and ischiorectal fossa,⁶ has been observed, as has bleeding or hematoma formation in the following portions of the alimentary tract: salivary gland,⁷ esophagus,⁸ stomach, duodenum, jejunum, ileum,² and colon.⁹ Signs of acute abdomen or bowel obstruction in patients receiving oral anticoagulant therapy may be a challenging clinical problem; therefore, we report on two patients with intramural hematoma of the intestine occurring during Coumadin® therapy.

CASE REPORTS

Case 1

A 45-year-old man was admitted because of abdominal pain and vomiting. Two years previously he had had a gunshot wound to the abdomen requiring repair of lacerations of the duodenum and liver. Eighteen months before the present illness, coronary artery vein bypass had been performed with good results. Since then he had taken Coumadin®, 10 mg daily; prothrombin times remained within satisfactory therapeutic level. He had abdominal pain and vomiting 36 hours before admission. Pain beginning in the epigastrium became generalized and was cramping, and the vomitus contained no blood.

The patient's vital signs were normal, lungs were clear to auscultation, heart was not enlarged, and cardiac rhythm was regular. Abdominal examination revealed a midline scar, diffuse direct tenderness and moderate rebound tenderness to palpation, and hypoactive bowel sounds. Rectal examination was normal, and the stool was guaiac negative. White blood cell (WBC) count was 15,900 with a shift to the left, hemoglobin 18 gm, and hematocrit 55 volumes percent. The prothrombin time was six times

the control (70/12) sec. Roentgenograms of the abdomen showed many air-fluid levels.

A diagnosis of small bowel obstruction, possibly due to hematoma, was made. With Vitamin K therapy the prothrombin time returned to normal. After nasogastric suction and intravenous fluid, the patient improved until 58 hours after entry when the abdomen showed increased distention and tenderness and bowel sounds were absent. At operation the abdomen contained approximately a liter of bloody fluid. Beginning at the distal jejunum, four feet of small bowel were dark blue and tense. The remaining small bowel and cecum showed many small areas of submucosal hemorrhage. The severely involved segment was resected and anastomosis performed. The patient's recovery was uneventful.

Case 2

A 46-year-old man developed acute thrombophlebitis in the left leg. He was given heparin and Coumadin® with good results. After appropriate warning concerning complications, he was given 7.5 mg of Coumadin® daily as an outpatient for two weeks. Forty-eight hours before admission, he developed post-prandial epigastric

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pain which became generalized. The following day the pain persisted, the vomiting stopped and he had no bowel movement.

On admission, blood pressure was 130/100, pulse 100, and temperature 101°F. His lungs were clear to auscultation and cardiac examination was normal. His abdomen was distended and diffusely tender, particularly in the lower abdomen. Rebound tenderness was present, guarding absent, and peristalsis diminished. Rectal examination was normal and the stool guaiac test was negative. WBC was 18,000 with a shift to the left, hematocrit 33 volumes percent, and the prothrombin time was five times the control value (60/12 sec). Roentgenograms of the abdomen showed dilated loops of small bowel and obliteration of

the left psoas line. A small amount of barium, given orally, showed obstruction of the distal segment of the duodenum (Figures 1A and B).

The patient was given Vitamin K intravenously and frozen plasma, and nasogastric suction was begun. He improved rapidly, pain and tenderness disappearing. The hematocrit, however, decreased to 26 volumes percent and Cullen's sign appeared. On the fourth day after admission, x-ray examination with barium showed a typical coiled spring sign in the jejunum (Figures 1C and D). After continued improvement he was discharged to be followed at his local hospital.

DISCUSSION

Intramural hematoma of the small bowel associated with thera-

peutic anticoagulation was first reported in 1952¹⁰; several cases have been described since. The acute onset of abdominal symptoms and signs of intestinal obstruction developing in a patient receiving anticoagulants should arouse suspicion of intramural bowel hematoma. Bleeding elsewhere associated with hypoprothrombinemia is further evidence. A barium roentgenogram study of the small bowel may reveal the coiled spring sign produced by the intramural hematoma.¹¹ Since patients on Coumadin® therapy frequently have serious cardiac or vascular disease which may be life-threatening, additional care must be exercised in their treatment.

Treatment consists of administration of a Vitamin K analogue to remedy the hypoprothrombinemia, correction of anemia, decompression of the gastrointestinal tract, and intravenous fluid and electrolyte therapy. A conservative regimen should be employed because of the serious nature of this condition and the usual associated diseases. If, after conservative therapy, the patient does not improve, or develops increasing pain, tenderness and guarding, surgery should be contemplated, principally because of the possibility of an error in the diagnosis. If surgery confirms the diagnosis, the condition may be treated by exploration only, bypass or resection of diseased bowel, depending on the findings. Although bowel necrosis due to intestinal hematoma is unlikely, two cases have been described.^{12, 13} Herbert,¹⁴ has reported 88 patients with intramural bowel hematoma. Forty-seven of those who were treated without operation recovered in three weeks. The remaining 41 patients were operated upon; one had exploration only, two had a bypass procedure, 38 underwent bowel resection, and five died.

SUMMARY

Patients receiving anticoagulant therapy may develop an intramural small bowel hematoma, causing intestinal obstruction and frequently signs of peritoneal irritation. Of the reported cases, nearly half were



Figs. 1A & B—Barium column stops in distal duodenum.
Figs. 1C & D—Later study demonstrating the characteristic coiled spring sign.

treated nonoperatively without a fatality.

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She was filled with energy and a great desire for usefulness, but it was not with her, as with many of her friends, that the natural instinct toward marriage, and the building and keeping of a sweet home-life, ruled all other plans and possibilities. Her best wishes and hopes led her away from all this, and however tenderly she sympathized in other people's happiness, and recognized its inevitableness, for herself she avoided unconsciously all approach or danger of it. She was trying to climb by the help of some other train of experiences to whatever satisfaction and success were possible for her in this world. If she had been older and of a different nature, she might have been told that to climb up any other way toward a shelter from the fear of worthlessness, and mistake, and reproach, would be to prove herself in most people's eyes a thief and a robber. But in these days she was not fit to reason much about her fate: she could only wait for the problems to make themselves understood, and for the whole influence of her character and of the preparatory years to shape and signify themselves into a simple chart and unmistakable command. And until the power was given to "see life steadily and see it whole," she busied herself aimlessly with such details as were evidently her duty, and sometimes following the right road and often wandering from it in willful impatience, she stumbled along more or less unhappily. It seemed as if everybody had forgotten Nan's gift and love for the great profession which was her childish delight and ambition. To be sure she had studied anatomy and physiology with eager devotion in the meagre text-books at school, though the other girls had grumbled angrily at the task. Long ago, when Nan had confided to her dearest cronies that she meant to be a doctor, they were hardly surprised that she should determine upon a career which they would have rejected for themselves. She was not of their mind, and they believed her capable of doing anything she undertook. Yet to most of them the possible and even probable marriage which was waiting somewhere in the future seemed to hover like a cloudy barrier over the realization of any such unnatural plans.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 159-160.

Follow-Up Study of Patients Discharged From an Alcohol Rehabilitation Center

Mary Castle, M.P.H.,* and Joan C. Cornoni, M.P.H., Ph.D.†

A DEFINED outcome measurement is useful in evaluating a health care service and its value to patients. Success-failure rates of a treatment program can be determined by patient follow-up; data measured at admission and remeasured after discharge can indicate outcome. The following investigation of 65 men who were patients at the Alcohol Rehabilitation Center (ARC) at Butner, North Carolina, during June and July, 1970, has been an attempt to determine changes in their health and life styles during a two-year period.

METHODOLOGY

At the first interview of ARC patients, demographic information was obtained, as well as histories of general health and drinking. We used the Iowa Index of Uncontrolled Drinking to identify problem drinkers¹ and to determine changes in problem drinkers after treatment. We also used the Health Opinions Survey (HOS) as a measure of "the effectiveness of mental health programs by redetermining the preva-

lence of psychiatric symptoms from time to time."² The 1970 survey is a baseline against which changes in the group's mental health status was measured.³

The second interview, held at the patient's home or place of employment, was to determine demographic changes during the two years after discharge; the HOS and the Iowa Index were repeated. Each person was asked to describe as specifically as possible his drinking behavior during the two years. Because many patients were sensitive to this type of questioning, in many instances the information was difficult or impossible to obtain, and therefore incomplete; the patient was not pressed for specific details when it seemed to threaten the rapport between the interviewer and the subject.

RESULTS

A flow sheet showing the success of casefinding was prepared (Figure 1). Because many patients could not be found for follow-up, the possibility of distorted results and biased sampling arose.⁴ Therefore, we compared those who were located with those who were not; the men who were found for the second interview did not differ significantly at the five percent level from those who were not, with respect to the variables measured.

Of the 31 men found for the second interview, 11 (35.49 percent) had abstained for nearly two years after discharge (Table 1). The remaining 20 drank periodically. When appropriate, the sample was divided into "drinkers" and "non-drinkers." The majority (63.6 percent) of the nondrinkers were married within two years after discharge from the ARC; 42.1 percent of the drinkers were married and 47.4 percent were separated or divorced. More than half (58.6 percent) of the sample population had not changed their place of residence during the two years; 72.7 percent of non-drinkers and 50 percent of drinkers were living in the same place. Of the 31 men, 64.5 percent were working full time; more non-drinkers were working full time (72.7 percent) than drinkers (60 percent), and 20 percent of the drinkers had been unemployed for a month or more, whereas none of the non-drinkers had been unemployed. Those who had worked at least a year with their present or last employer comprised 41.9 percent, but each subgroup had a relatively large number working less than six months—drinkers 40 percent, and non-drinkers 27.3 percent. Of the number of jobs held for the two years, the entire sample showed the largest percentage (35.5 percent) as

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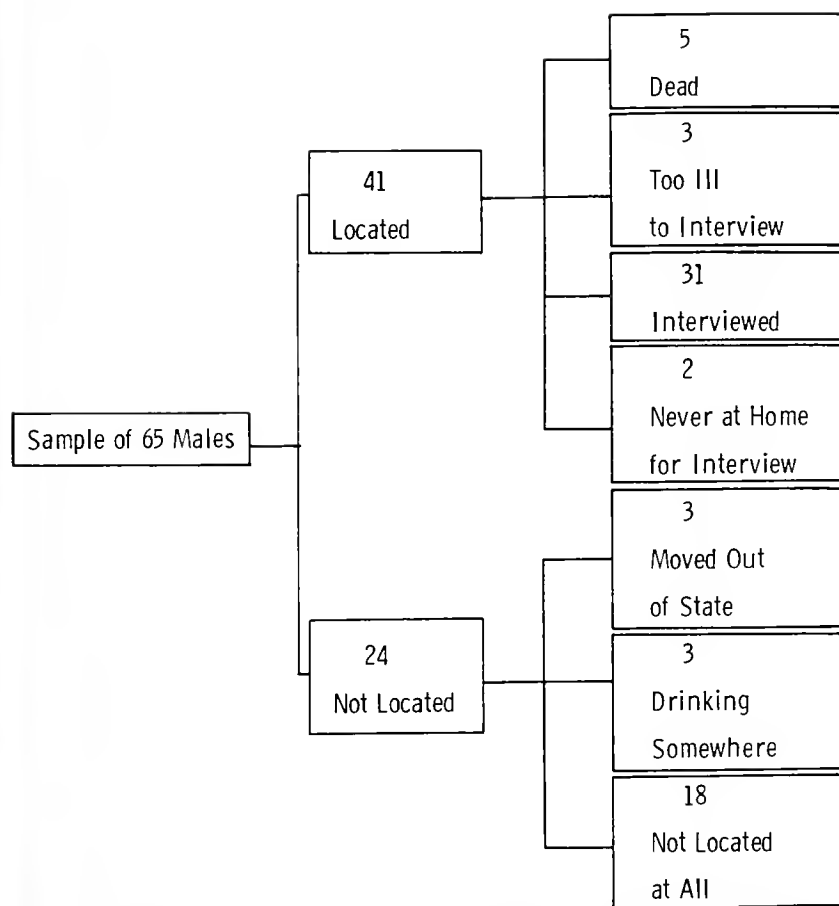


Fig. 1. Flow chart of sample of 65 men discharged from the Alcohol Rehabilitation Center at Butner in 1970.

having had one job; however, drinkers had more jobs than non-drinkers. Thirty percent of the drinkers had three or more jobs, compared with 9.1 percent for the non-drinkers.

We obtained information based on education and job level for 29 persons.⁵ Of jobs held by the entire sample, 69 percent were in the two lowest categories; of the jobs held by the drinkers, 50 percent were ma-

chine operators and semi-skilled employees, whereas 54.5 percent of the non-drinkers were skilled manual employees. Most of the men sampled (51.7 percent) were at least high school graduates; proportionately more drinkers (55.6 percent) than non-drinkers (45.4 percent) had at least a high school education. The majority of the entire sample was in the two lowest social classes; more drinkers than non-drinkers were in the lower classes.

At the time of the second interview, 18 (51.6 percent) of the men were "dry" (not drinking). Sixty-eight percent had no readmissions to the ARC, but 12 percent had two or more readmissions; those who had been drinking during the two years had more readmissions; nine percent of the non-drinkers were readmitted, whereas 45 percent of the drinkers were readmitted at least once.

According to the Mulford Index of Uncontrolled Drinking, of the 31

problem drinkers the mean score for the first interview was 7.9 (any score over zero indicates a positive answer to a question about drinking); on the second interview, 14 had scores of zero or one; nine were non-drinkers and five were drinkers. The mean score of the total group on the second interview was 3.2, indicating that former inpatients still had drinking problems. Positive answers were obtained primarily in matters of family, finances, personal motivation, and drinking control; fewer positive replies were received at the second interview; the mean number of positive replies of the 31 men for the first interview was 15.67 per question, compared with 5.75 per question for the second interview.

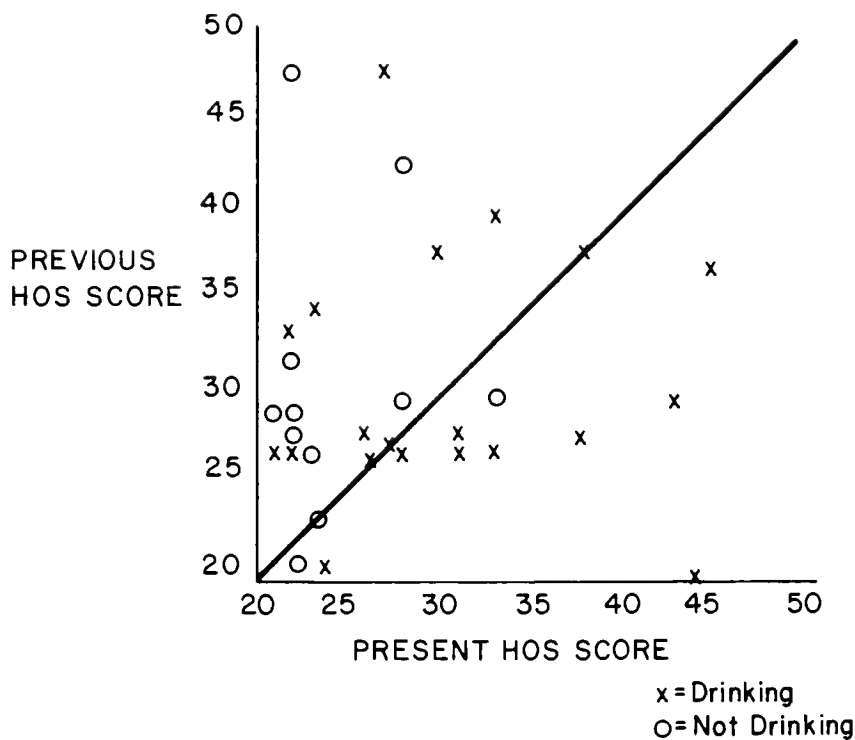
The total group showed general improvement (lower scores) in HOS scores at the second interview: low, 20-29; borderline, 30-34; and high, 35+. Nine (29.0 percent) moved from high to low categories, and six (19.3 percent) moved from low to high categories. On the second interview, the non-drinkers showed greater improvement (low scores) than drinkers; none of the non-drinkers had higher scores, whereas 30 percent of the drinkers had higher scores than previously. Figure 2 shows changes in HOS scores in drinking behavior among the 31 men for the two year period: The diagonal line shows those whose scores were identical on both interviews; eliminating those that lie on the line, the scores to the left of the line reflect improvement in mental health; those to the right reflect change toward a less healthy status, indicating that abstainers had benefited from treatment at the ARC. Table 2 shows the apparent

Table 1
Frequency of Drinking for 31 Men Over Two Year Period After Discharge From ARC

Duration of Abstinence	No.	Percent Total
Non-Drinkers		
Abstained for 2 years	8	25.81
Abstained for 2 years minus one weekend	3	9.68
Drinkers		
Abstained for periods of 1-6 months	8	25.81
Abstained for periods less than 1 month	10	32.26
No Abstinence; continuous drinking	2	6.45
Total	31	100.00

Table 2
Number of Persons Having Less and More Healthy Scores on HOS Time of Second Interview, by Categories of Drinking and Not Drinking

Scores	No. Drinking	No. Not Drinking	Total
Less healthy	9	2	11
More healthy	8	8	16
Total	17	10	27



The diagonal line represents no change in HOS score.

Fig. 2. First and second interview scores of 31 men, by categories of drinking and not drinking.

association between drinking and a high HOS score.

DISCUSSION

Of the 31 men interviewed two years after discharge from the ARC, slightly more than half had abstained from alcohol for a month or more; only one-third, however, had remained "dry" for the two years. The drinking behavior of the remaining two-thirds ranged from periodic binges to continual heavy drinking. The validity of these results might be questionable since they are based upon patient-reported histories. Other sources — relatives, police or public health department records — could have been helpful in verifying the results, but there was not sufficient time for this kind of follow-up.

According to the American Medical Association, success and failure in aiding the alcoholic should not be taken at face value.⁵ "Success" and "failure" need to be redefined in terms other than simply drinking and not drinking. However, in the course of our study, several patients who admitted drinking one or two beers a day appeared to be success-

fully carrying out their daily activities and maintaining their social and marital relationships. Although other follow-up studies on alcoholism show a low rate of abstinence, this should not detract from the significant numbers of those who drink in moderation or those who have improved their drinking habits and life style.⁶ Definitions of outcomes, and decisions based on them need to be clarified to help patients re-evaluate their responsibilities to themselves, their families and society.

Our sample showed general improvement in mental health, based on results from the Mulford Index of Drinking Behavior and the Health Opinions Survey; however, these results may be distorted since some patients probably overestimated their improvement in drinking, as a result of the social desirability of certain responses.^{7, 8} Nevertheless, relative changes may be investigated on a before-and-after self-report.

The HOS scores indicated that after treatment at the ARC, more abstainers improved in HOS scores than did drinkers during the two

years after discharge. These findings point to the need for an index, for use during hospitalization, to identify problems that can arise among patients after discharge; it could permit followup care to be concentrated on those patients most likely to have problems.

SUMMARY

The follow-up of patients discharged from the Alcohol Rehabilitation Center at Butner, North Carolina, resulted in the location and interview of 48 percent of our patient population of 65 men. The Mulford Index of Uncontrolled Drinking showed general improvement in drinking problems among the men in the sample during the two year period following discharge. At the time of follow-up, 35 percent of these patients had abstained. A higher percentage of men who were married, working full time, having fewer job changes and fewer changes in place of residence was found among the abstainers. The drinkers and abstainers also showed differences in scores on the Health Opinions Survey, a measurement of mental health. The study indicated the need for further investigation using the Health Opinions Survey to evaluate treatment of alcoholism, as well as the need for clearer definitions of "success" and "failure" and criteria for outcome measurement.

ACKNOWLEDGMENT

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To a Louse

H. A. Matthews, M.D.*

LIKELY, in 1786, Robert Burns saw a louse on a fancy lady's bonnet at church. Inspired as poets heretofore were not by lowly subjects, the Scotch poet wrote:

TO A LOUSE

I

Ha! where ye gaun, ye crowlin ferlie?
Your impudence protects you sairly,
I canna say but ye strunt rarely
Owre gauze and lace,
Tho' faith! I fear ye dine but sparely
On sic a place.

II

Ye ugly, creepin, blastit wonner,
Detested, shunn'd by saunt an'
sinner,

How daur ye set your fit upon her—
Sae fine a lady!
Gae somewhere else and seek your
dinner
On some poor body.

VI

I was na been surpris'd to spy
You on an auld wife's flainen toy;
Or aiblins some bit duddie boy,
On's wyliecoat;
But Miss's fine Lunardi! fye!
How daur ye do't?

For whatever reasons, infestation with human lice has been on the increase on the college campus and elsewhere, even during the decline of the "hippie" life style. Incidence has increased among groups with high standards of sanitation, and the physician need not be surprised to see a "crowlin ferlie" on any "Miss's fine Lunardi."

The common and scientific names

of human lice (*Pediculus*) accepted by the Entomological Society of America, and common synonyms are:

head louse: *Pediculus humanus capitis* De Geer, or in older literature *Pediculosis capilis* De Geer

body louse: *Pediculus humanus humanus* Linnaeus, or *Pediculus corporis* De Geer, or *Pediculus vestimenti* Nitzsch

crab louse: *Phthirus pubis* (Linnaeus), or in older literature *Phirius inquinales* Leach

Most likely, Burns was observing a *Pediculus humanus humanus* Linnaeus. All the species have some characteristics in common: they are sucking insects which establish and maintain themselves only on human beings; hence, human lice. They are not caught from the new cat.

Practical considerations in distinguishing the critters are:

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SUBSPECIES	HABITAT	APPEARANCE	SIGNS
Head louse	Elects head hair.	Much like body louse but slimmer. Dirty white to blackish gray but can adapt to coloration. (Blond lice on blonds.)	Nits (eggs) on hair roots and at times posterior cervical lymph nodes.
Body louse	Prefers living in clothing with attachment of nits to clothing fibers, moving to arm pits and belt area for feeding.	Much the same size but rounder than head louse. Dirty blackish-gray and no blonds.	Only infrequent nits on body hair; really not expected.
Crab louse	Infests pubic hair and only occasionally hair elsewhere.	Adults grayish-white to slightly pink.	Nits attached only to body hair. Blue spots on skin.

Immature lice (nymphs) look like the adult, but smaller. Young head and body lice have very much the same appearance as do their nits. If Burns' society lady had had head lice, he might have seen a nit on a hair and no louse on the bonnet. The human lice do firmly attach their nits to hair (the head and crab louse) or clothing (the body louse) by a ring of cement. Each nit has a cap (operculum) which comes off intact when it hatches. After the nit has hatched, the cement-like attachment and shell may remain on the hair after thorough washing or shampooing.

Awareness of these characteristics may prove to be practical in the detection of nits, which can lead to diagnosis even if hatched lice are not located. Whereas the live nit is oval in shape and yellowish opalescent in color and gives a cracking feel when compressed between thumb nails, the hull has lost its opalescence and does not crack with pressure, but it too is frequently firmly attached.

Students tend to overtreat lice infestation. While some respond to the adage of not beating a dead dog, all are advised to comb their previously lousy heads with a fine-tooth comb or to pick off the dead hulls. The practice prevents some anxiety

and demand for excessive treatment. Rarely, during suite-confined panic (we have had no epidemics), young ladies in particular may become unduly concerned about collected hair spray at the roots or hair cast nodules. While these easily slide up and down the hair, the nit and nit shell pull off or remain, due to their cement-like substance.

Only the body louse has been definitely implicated as a vector in louse-born relapsing fever and epidemic typhus, but neither has been reported in the United States in almost 40 years. Even so, the bites of the body louse are annoying, and in persistent infestation the skin becomes hardened and darkly pigmented — "vagabond's disease," which has been seen frequently on the Bowery and in migrant labor tenements in the Connecticut Valley and elsewhere. Only two students have been treated for "the vagabonds" on our campus during the past six years. Still, isolated bluish discolorations are at times helpful in distinguishing the body louse.

The life styles of all the human lice and all the lousy hosts are further clues to management of the one-sided love affair. Lice love the human being and most lice in present day America are picked up by lov-

ing. Head lice may be caught by ill-advised use of combs and brushes; body lice can easily be picked up from clothing; and crabs from hairs on toilet seats (hence, the seats should be left up when not in human use).

The female of all three subspecies may lay 200 or more nits a day for ten days and the average generation is completed in three weeks. When off the hosts, all stages can be expected to die within 30 days regardless of temperature. Unfed lice survive up to ten days, depending upon temperature. Thus, sleeping bags should be laundered or dry-cleaned or not used for about two weeks. Lice and nits in clothing are killed in exposure to the heat of commercial washing machines at the usual 30-minute cycle; experimentally, they have failed to survive 24 hours at 14 F (-10 C) or 12 hours at 5 F (-15 C) and 30 minutes at 122 F (50 C); hence, all human lice can usually be killed in bedding, clothing, and on furnishings by heating, freezing, or leaving to time without host contact.

The host usually responds well to any of the following list of pediculicides published by the United States Department of HEW, Public Health Service, Vol 18, No. 5:

Brand Name ^b	Active Ingredients (Percent)	Manufacturer or Distributor	Length of Application
<i>No Prescription Required</i>			
A-200 Pyrinate (shampoo)	Pyrethrins—0.165 Piperonyl butoxide—2 Deodorized kerosene—5	Norcliff Laboratories, Inc., Fairfield, CT 06430	At least 10 minutes
Cuprex (lotion)	Tetrahydronaphthalene—30.97	Calgon Corp., Pittsburg, PA 15230	15 minutes
Bomate (lotion)	Copper oleate—0.33 Isobornyl thiocyanacetate—5 Diocetyl sodium sulfosuccinate—0.6	Wyeth Laboratories, Inc., Philadelphia, PA 19101	10 minutes, but no longer
<i>Prescription-Required</i>			
Topocide (lotion)	Benzyl benzoate—12 Benzocaine—2 DDT (dichloro-diphenyl-trichloroethane)—1 [concentrate known as NBIN]	Eli Lilly & Co., Indianapolis, IN 46206	48 hours; repeat after 7-10 days if necessary ^c
Kwell Shampoo	Lindane (gamma benzene hexachloride)—1	Reed & Carnrick Kenilworth, NJ 07033	4 minutes
Kwell Lotion	Lindane (gamma benzene hexachloride)—1	Reed & Carnrick Kenilworth, NJ 07033	12-24 hours
Kwell Cream	Lindane (gamma benzene hexachloride)—1	Reed & Carnrick Kenilworth, NJ 07033	12-24 hours

^a All listed preparations kill louse nits, nymphs and adults.

^b Brand names are cited for the convenience of the purchaser, and do not constitute endorsement over similar products available under other brand names, or insecticidal preparations which do not appear on this list.

^c The manufacturer's directions for the use of Topocide give 10 days as the length of application for head lice and 2 days for pubic lice. Other sources, while recommending 24-48 hours for both pubic lice and head lice, state that it may be necessary to repeat treatment.

Kwell Shampoo for head lice and Kwell Lotion or Cream for body and crab lice may be preferred since the odor is inoffensive and the prescription affords health education and public health counseling. Many students, perhaps most purchasing over-the-counter medication, too frequently suffer unduly from anxiety and over-treatment before they come in for help. As noted, few treat their hair and normal follicle casts with one of these agents. Leaving the Kwell on for 24 hours allows the patient to carry out control measures.

Routinely, the student is requested to return in four days for examination of excoriations, possible secondary infections, anxiety, and the thoroughness of personal control measures, and for possible contact follow-up. While preventive measures should be compulsory in all cases, those involving body lice should emphasize thoroughness in cleaning clothing, bedding, sleeping bags, couches and other contact sources.

In his "To a Louse," Burns concluded:

VIII

O wad some Power the giftie gie
us
To see oursels as ithers see us'
It was frae monie a blunder free us,
An' foolish notion:
What airs in dress an' gait wad lea'e
us,
An' ev'n devotion!

There are reasons to question the conclusion by Burns, but it need not be questioned that he knew more about lice and people than most students.

"I am going to be a doctor, too! I have thought it would be best thing in the world ever since I can remember." It seemed to her as if the first volume of life was ended, and as if it had been deceitfully easy, since she had been led straight-forward to this point. It amazed her to find the certainty take possession of her mind that her vocation had been made ready for her from the beginning. She had the feeling of a reformer, a radical, and even of a political agitator, as she tried to face her stormy future in that summer morning loneliness. But by the time she had finished her early breakfast, and was driving out of the gate with the doctor, the day seemed so much like other days that her trouble of mind almost disappeared. Though she had known instinctively that all the early part of her life had favored this daring project, and the next few years would hinder it if they could, still there was something within her stronger than any doubts that could possibly assail her. And instead of finding everything changed, as one always expects to do when a great change has happened to one's self, the road was so familiar, and the condition of the outer world so harmonious, that she hardly understood that she had opened a gate and shut it behind her, between that day and its yesterday.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 174-175.

Editorial

NOTES FROM HOME

From time to time things happen in North Carolina which deserve recognition and comment. This month the JOURNAL would like to thank, belatedly, Dr. Christopher Fordham for calling our attention to a "Personal View of North Carolina" by an English physician, published last year in the *British Medical Journal*.¹ Dr. Trimble has praise for our geography, our climate and especially for our efforts to improve medical care in rural areas and for our results. One quotation concerning financing medical care: "In the land of Protestant ethic, that has mistrusted government since the days of George III, the concept of total government financing, which inevitably means under-financing, in such a delicate area as health care is inconceivable."

In a state with many farmers, problems of medical care include not only attracting physicians to thinly populated and sometimes economically poor areas, but also being aware that occupational illnesses in the country differ from those in the cities. Dr. Gehlbach and his colleagues² in the pesticides program of the Division of Health Services have recently described green tobacco sickness, "a self-limited illness characterized by pallor, vomiting and prostration" occurring in young non-smoking males handling the uncured leaf. Symptoms are attributed to absorption of nicotine,³ particularly when tobacco is wet; smoking appears to be protective. Asking ex-farm boys about Dr. Gehlbach's findings has provided retrospective confirmations, and not a few reported that they had been paddled for smoking by their irate fathers.

Patterns of drug use differ too in rural areas and small towns, as experience with bromidism and analgesic abuse in the South confirms, while a richly varied flora offers further challenge to those who would seek new psychic horizons. One needs only to examine the new second edition of Hardin's and Arena's *Human Poisoning from Native and Cultivated Plants*,⁴ and to remember that people, as well as longhorn cattle, "feed on the lowly Jimson weed" whose seeds are well laced with belladonna alkaloids, to appreciate the possibilities.

References

1. Trimble M: Br Med J 1: 608, 1974.
2. Gehlbach SH, Williams WA, Perry LD, Woodall JS: JAMA 229: 1880-1883, 1974.
3. Gehlbach SH, Williams WA, Perry LD, Freeman JI, Langone JJ, Peta LV, Van Vunaris H: J Incest 1: 478-480, 1975.
4. Hardin JW, Arena JM: Human Poisoning from Native and Cultivated Plants, 2nd ed, Duke University Press, Durham, 1974.



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Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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Correspondence

INSECT BITES

To the Editor:

Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, and others.

I would like for physicians to supply me with case reports of those patients who have had reactions to such insect bites. Please include in your

reports the type of reaction; complications, if any; age, sex and race of the patient; site of the bite(s); season of the year; immediate symptoms; skin test results; desensitization results, if any; and associated allergies. Anyone who is interested may send this information to the following address:

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Emergency Medical Services



PRIORITIES FOR ESTABLISHING A RURAL EMERGENCY MEDICAL SERVICES SYSTEM

The Council on Rural Health and Committee on Community Emergency Service

The Council on Rural Health and Committee on Community Emergency Services share a concern for developing and upgrading emergency medical services in rural areas. The first aims to ensure availability and accessibility of health services for rural America, whereas the latter works toward effective emergency medical services for all people. With the current maldistribution of health manpower in rural areas, the problem of providing emergency medical services becomes difficult, although not impossible. Facilities, financial resources, public transportation, and road networks may be limited, adding to the problem.

The four basic components of a good emergency care system are: (1) broad-based training; (2) communication systems; (3) well-equipped vehicles, staffed by well-trained technicians; and (4) high-quality emergency care facilities, staff and equipment. In order to coordinate these components, a community council or emergency medical service council must be formed to bring together the leaders providing such care for planning, education and funding.

While the majority of the nation's population is urban, the majority of highway fatalities are rural. More than 6,000 farm residents each year die as a result of farm, home, and highway accidents. The Emergency Medical Services Act of 1973 offers rural communities a major source for establishing or up-

grading emergency service programs. Thus, not less than 20 percent of the grants and contracts shall serve rural areas.

Certain minimum needs for a rural emergency medical service are: (1) a two-way radio capable of contacting other hospital and all emergency vehicles; (2) a nurse or physician's assistant in the hospital at all times; (3) appropriate protocols to cover emergency activities while the physician is en route to the hospital; (4) a physician trained in emergency medicine on call to the hospital; (5) laboratory and x-ray technicians available; (6) minimal equipment available; (7) an emergency department committee; (8) proper signs identifying the local of the hospital; (9) a formal plan for primary coverage at all times by physicians; (10) a formal plan readily available to the emergency room covering the types of patients to be provided with basic emergency care only and then transferred; (11) a record of patient problems.

Thus, the local community is encouraged to organize a rural emergency medical service system which will include a rural hospital, and to be informed and consider the feasibility of using the resources available through the Emergency Medical Services Systems Act of 1973.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," Vol. 4, No. 2, February 1975, John M. Howard, M.D., Editor. Original article may be obtained from Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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WHAT? WHEN? WHERE? In Continuing Education

May 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

May 15-16

Recognition and Management of Common Gynecological Abnormalities
 Fee: NCSNA members \$15; non-members \$30
 For Information: North Carolina State Nurses Association, P. O. Box 12025, Raleigh 27605

May 22-24

Successful Treatment of the Elderly Mentally Ill
 Sponsor: Older Americans Resources and Services Program of the Center for the Study of Aging and Human Development
 Program: Designed for psychiatrists, internists, family practitioners, nurses, social workers, psychologists and pastoral counselors, in relation to their work with older patients
 For Information: Dorothy Heyman, Box 3003, Duke University Medical Center, Durham 27710

May 23

Perinatology Postgraduate Course
Place: 103 Berryhill Hall
Sponsors: Department of Pediatrics; Office of Continuing Education
Registration: pre-registration requested
Credit: 6 hours; AAFP credit applied for
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

May 23-24

Neurologic Problems in Children
Place: Babcock Auditorium
Fee: \$25
Credit: 6 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 25-27

Continuing Education for Emergency Medical Technicians—designed for ambulance, civil defense, emergency medical technicians, emergency squads, volunteer rescue squads, firemen and policemen.
Sponsor: American Academy of Orthopaedic Surgeons
Fee: \$75; certification of completion of the Department of Transportation 81 hour Course is a prerequisite for registration.
For Information: H. William Tracy, M.D., 1822 Brunswick Avenue, Charlotte 28207

May 28-29

26th Annual Scientific Sessions of the North Carolina Heart Association
Place: Winston-Salem Hyatt House and Convention Center
Fee: Physicians and Medical Scientists \$20; Others, \$10, except no fee for students, interns and residents. Registration fee includes cost of banquet and breakfast.
Credit: 5 hours; AAFP credit applied for
Note: Special sessions will be held for cardiology technologists, emergency medical personnel, technologists and for volunteers
For Information: Norris B. Harbold, M.D., North Carolina Heart Association, P. O. Box 2408, Chapel Hill 27514

June 3-5

Rehabilitation of the Patient with Myocardial Infarction—An Interdisciplinary Approach
Place: Carrington Hall
Sponsors: Continuing Education, UNC School of Nursing; Division of Physical Therapy, Department of Medical Allied Health Professions, UNC School of Medicine; North Carolina Heart Association
Fee: Registration \$15
For Information: Barry R. Howes, Assistant Professor, Department Medical Allied Health Profession, UNC School of Medicine, Chapel Hill 27514

June 16-18

North Carolina Hospital Association Annual Meeting
Place: The Grove Park Inn, Asheville
For Information: Diane Turner, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

June 20-22

New Advances in Diagnosis and Treatment of Pediatric Pulmonary Diseases
Place: Quail Roost Conference Center, Creedmoor
Registration: limited to 40 pediatricians, internists or family practitioners
Credit: 11 hours; AAFP approved
For Information: Alexander Spock, M.D., P. O. Box 2994, Duke University Medical Center, Durham 27710

July 14-19

Duke Medical Postgraduate Course
Place: Atlantis Lodge, Atlantic Beach
Fee: \$125
Credit: 30 hours; AAFP credit applied for
For Information: William J. DeMaria, M.D., Assistant Dean, Office of Continuing Medical Education, Duke University Medical Center, Durham 27710

July 21-26

Postgraduate Course in Radiology
Place: Atlantis Lodge, Atlantic Beach (near Morehead City)
Fee: \$150; designed for radiologists, but open to all physicians. Enrollment limited to 75
Credit: 30 hours
For Information: Robert McLelland, M.D., Department of Radiology, P. O. Box 3808, Duke University Medical Center, Durham 27710

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop
Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
Sponsors: Divisions of Continuing Education, Bowman Gray, Duke, and UNC Schools of Medicine, and the Medical College of South Carolina
Fee: \$100
Credit: 20 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 5-6

North Carolina Chapter of the American Academy of Pediatrics and the North Carolina Pediatric Society—Annual Meeting
Place: Blockade Runner, Wrightsville Beach
For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 12-13

1975 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery. Main emphasis will be upon trophoblastic disease, vulvar malignancies, and endometriosis. Invited guests include Dr. John Lewis, New York; Dr. George Morley, Ann Arbor, Michigan; and Dr. Hugh Shingleton, Birmingham, Alabama.
For Information: W. T. Creasman, M.D., Director, Gynecologic Oncology, Box 3079, Duke University Medical Center, Durham 27710

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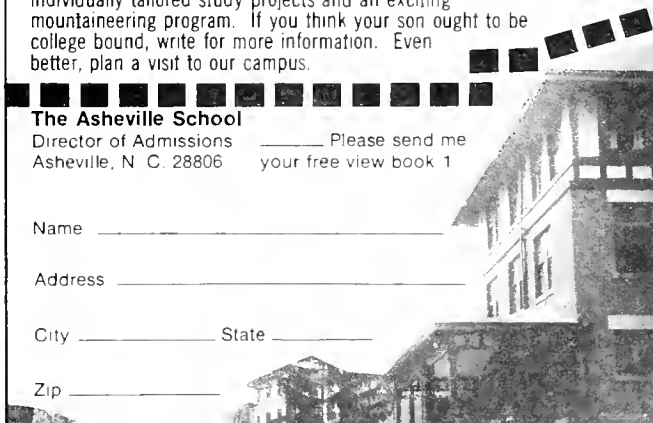
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September 12-13

North Carolina Association of Blood Bankers Annual Convention

Place: Sheraton Inn, Charlotte

For Information: Roy A. Weaver, M.D., President, P. O. Box 2000, Cape Fear Valley Hospital, Fayetteville 28302

September 12-14

Legislative Workshop: this institute will bring together members of the North Carolina Medical Society and persons from the legislative and executive branches of North Carolina state government, so that North Carolina physicians may gain a better understanding of the process of government

Place: Center for Continuing Education, Appalachian State University, Boone

Sponsors: North Carolina Medical Society and Smith Kline & French Laboratories

For Information: Stephen C. Morrisette, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter, American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital

Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists Annual Conference

Place: Benton Convention Center, Winston-Salem

Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education, scientific exhibits and a display of commercial equipment.

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 3-7

Current Concepts in Pediatric Radiology

Place: Pinehurst Hotel, Pinehurst

Program: There will be a systems oriented format covering cardio-pulmonary diseases on Monday, gastro-intestinal diseases on Tuesday, genito-urinary diseases on Wednesday and musculo-skeletal diseases on Thursday, "with Friday left for miscellaneous disorders."

Credit: 25 hours

For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham 27710

OTHER ITEMS OF INTEREST

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association

Place: Miami Beach, Florida

For Information: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205

Seminars in Cardiology

May 20—Rehabilitation Following Myocardial Infarction

June 17—Exercise Testing

Place: C. J. Harris Hospital, Sylva

Program: Physicians who will be in attendance are encouraged to refer any of their patients who present unusual treatment problems. During the morning, patients will be seen by a consulting cardiologist from the UNC or Bowman Gray Schools of Medicine, and by other physicians. The first part of the afternoon will consist of case presentations, and a lecture pertaining to the specific disease entity on which the respective seminar is focused. The last part of each seminar afternoon will consist

of a lecture and demonstration in electrocardiography
Sponsors: Jackson County Medical Society; Health Education Commission of Western North Carolina

Credit: AAFP credit applied for

For Information: Ralph S. Morgan, M.D., Box 668, Sylva 28779

Nursing Equivalency Exams Available

The North Carolina Nursing Equivalency Examinations, "designed to give licensed practical nurses and other individuals an opportunity to get college credit toward the first year's work in an Associate Degree (ADN) Program," are now available at six College-Level Examination Program test centers in North Carolina.

To apply, contact one of the following: Dr. D. W. Proctor, Director of Guidance, Gardner-Webb College, Boiling Springs 28017; Mrs. J. G. Bailey, Director of Testing, East Residence Hall, ASU, Boone 28607; Dr. R. B. Simono, Director, Counseling Center, UNC, Charlotte 28202; Dr. L. M. McManus Jr., Director, Counseling Center, Fayetteville State University, Fayetteville 28301; Miss E. Saunders, Director, Guidance & Placement, Methodist College, Fayetteville 28301; Mr. R. K. White, Counselor, NCSU, Box 5505, 210 Peele Hall, Raleigh 27607.

Developed by the North Carolina Regional Medical Program in cooperation with the College Entrance Examination Board and Educational Testing Service, the examinations were made possible by grants from the United States Public Health Service and the Kate B. Reynolds Health Care Trust.

For an informational booklet of descriptions, sample questions and score information contact: College Board Publications Orders, Box 2815, Princeton, New Jersey 08540

Annual Session CME Credit

Participation in three activities in conjunction with attendance at the 121st Annual Session of the North Carolina Medical Society may be counted toward meeting continuing medical education membership requirements up to the following maximums, based on the number of your contact hours of participation: general sessions, 6 hours; audio-visual program, 12 hours; Section on Family Practice, 1 hour.

Family Practice Examinations

The American Board of Family Practice Certification Examination

Place: "five centers geographically distributed throughout the United States"

Fee: Application \$50; examination \$300; deadline for receipt of applications is June 15, 1975

For Information: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Kentucky 40506

PROGRAMS IN CONTIGUOUS STATES

May 16-17

Workshop on Practice Productivity

Place: Fairmont Colony Square Hotel, Atlanta, Georgia

Fee: \$345, plus \$35 for each of your Medical Assistants who is enrolled. Enrollment limited to 22 physicians.

Program: Designed to help you (1) control your time, (2) control your telephone, (3) utilize your staff, (4) reduce your paper-work load, (5) improve patient scheduling and work flow. Medical Assistants Workshop meets for 5½ hours on the first day only.

For Information: The American Council of Otolaryngology, Suite 602, 1100-17th Street, N.W., Washington, D. C. 20036, or phone toll free 800-421-6512.

October 20-21

Tennessee Valley Medical Assembly annual meeting

For Information: Clifton R. Cleaveland, M.D., Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

**UNIVERSITY OF NORTH CAROLINA
DIVISION OF HEALTH AFFAIRS**

Dr. Cecil G. Sheps, vice chancellor for health science at UNC-Chapel Hill, has been elected to the editorial board of a new health journal, *Social Work in Health Care*.

* * *

Five North Carolinians received the UNC School of Medicine's highest honor, the Distinguished Service Award, on March 27. They were: Norma Connell Berryhill of Chapel Hill, wife of the former UNC medical dean; internist Dr. David Sanford Citron of Charlotte; Congressman L. Richardson Preyer of Greensboro; family physician Dr. Rose Pulley of Kinston; and, Dr. Charles Durward Van Cleave, UNC emeritus professor of anatomy.

* * *

Dr. Robert W. Winters, a pediatrician from Columbia University College of Physicians and Surgeons, delivered the annual Adam Thorpe Memorial Lecture April 3 at the UNC School of Medicine. New members of Alpha Omega Alpha medical honorary were honored.

* * *

Dr. William D. Mattern, assistant professor of medicine, has been named a Teaching Scholar of the American Heart Association. The Association awards two scholarship each year to encourage qualified medical teachers to devote their time to teaching and improving teaching methods.

Dr. Mattern will receive an average of \$15,000 a year for the next five years. He plans to develop a series of self-instruction programs to help medical students better understand how to treat patients with severe kidney disorders.

* * *

Dr. Robert McCurdy of Denver, Colorado, received the Sidney S. Chipman Award as the most outstanding alumnus of the UNC Department of Maternal and Child Health.

* * *

The Burroughs Wellcome Fund has made a \$100,000 special award in clinical pharmacology to the UNC School of Medicine to enable the school to develop a new division of clinical pharmacology.

* * *

Childhood malignancies was the focus of UNC's annual Malignant Disease Symposium on March 28.

* * *

Scientists have known for years that exposure to loud noise can cause hearing loss. But there is no general agreement regarding how loud a noise must be to impair hearing, how long a person can safely be exposed to a noise without sustaining hearing

loss or what constitutes a hearing impairment as opposed to a hearing handicap.

Two North Carolinians, Dr. William Grady Thomas of the UNC School of Medicine and Dr. Larry H. Royster of N. C. State University, are trying to resolve some of the disagreements. Working under a \$47,400 grant from the Rockefeller Foundation, they will analyze hearing data from approximately 100,000 employees in tobacco, textile, furniture and general industries.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Wayne Rundles, professor of medicine, received the Annual National Divisional Award from the North Carolina Division of the American Cancer Society at a recent statewide meeting of the society in Raleigh. The physician and scientist, head of the Hematology and Chemotherapy Service here, has worked with the North Carolina division and the National American Cancer Society for more than 20 years in all areas of cancer control.

* * *

A Duke researcher has received the 1975 Albion O. Bernstein, M.D. Award. The Medical Society of the State of New York selected Dr. D. Bernard Amos, James B. Duke Professor of Immunology and chief of the Division of Immunology, for what it termed "your significant contributions in the fields of immunology and genetics. The far-reaching implications of your work will be increasingly appreciated as we forge more deeply into the field of tissue and organ transplantation." Amos's name was submitted as a candidate for the award by the executive committee of the Duke medical faculty.

The award, presented before the society's House of Delegates, consisted of a scroll and \$2,000. The society said the Bernstein Award goes to an individual "who has made an outstanding contribution with great promise for the advancement of medicine." It was established by the father of a young physician who lost his life while responding to a medical call.

* * *

The university's Video Interaction Program (VIP), sponsored during its initial year by the N. C. Regional Medical Program, has received a \$120,000 grant to support its operations for the next two years from the Kate B. Reynolds Health Care Trust of Winston-Salem.

VIP, a program of the Department of Community Health Sciences, takes portable videotape equipment into local homes and offices to help discover the health needs of the community. It has accumulated televised tapes of interviews with Durham area citi-

zens talking about the treatment they have received as outpatients at Duke hospital.

With direct in-put from health care consumers on videotape, the VIP staff can give health care professionals "the chance to hear, in the words of the consumer, about the problems they're encountering in getting the treatment they need," said VIP director Richard Ainsworth.

* * *

Dr. Wiley D. Forbus, professor emeritus and chairman of the Department of Pathology for 30 years, was honored in New Orleans recently when the American Association of Pathologists and Bacteriologists named him the 23rd recipient of the Gold Headed Cane Award, created in 1919 to honor "a pathologist representing the highest ideals in pathology and medicine."

Duke's first chairman of pathology, Forbus headed the department from 1930-60, and he continues to maintain an office here where he works on his own projects. He has worked actively and lectured widely for improvement of medical education, particularly pathology. He helped modernize medical schools and pathology laboratories in Taiwan, Japan, China and Indonesia.

Long a promotor of forensic medicine, Forbus led an extended campaign to revamp North Carolina's coroner system. His efforts resulted in the General Assembly's passage of a bill in 1955 to create the medical examiner system in this state.

* * *

The History of Medicine program is being expanded and strengthened through a two-year, \$53,600 grant from the Josiah Macy Jr. Foundation of New York City, which in 1966 provided initial support to establish a History of Medicine curriculum at Duke.

In the program a small number of selected students who anticipate academic careers are financially supported in earning jointly doctorates in medicine and history. In each of the four years from 1967-70, one student was admitted.

The first student, Dr. Russell Maulitz, received his degrees in 1973 and has joined the faculty at the University of Pennsylvania.

Dr. Robert Powell, who also has received both his M.D. and Ph.D. degrees, will join the faculty at the University of Missouri in Kansas City following a year of training in psychiatry in Syracuse, N. Y.

Four students are currently in various phases of their studies. The new Macy grant will be used to add a faculty member and secretarial help.

"The presence of an M.D.-Ph.D. student in the medical school classes has had a definite stimulating effect in raising the interests of fellow students in the history of medicine," said Dr. Gert H. Brieger, who has headed the program since 1970. The addition of another historian in medicine, he said, "will

Rondomycin

(methacycline HCl)

CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Use in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Use in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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minimum *in vitro* inhibitory concentrations**

*Since many strains are known to be resistant, routine sensitivity testing is recommended

enable us to increase the course offerings, thereby providing more teaching in the history of medicine, both graduate and undergraduate."

News Notes from the—

**BOWMAN GRAY SCHOOL
OF MEDICINE
WAKE FOREST UNIVERSITY**

The appointment of six full-time and eight part-time faculty members at Bowman Gray was announced recently.

Joining the full-time faculty are Dr. Larry D. Camp, instructor in the Section on Allied Health Programs; Dr. Charles H. Duckett, associate professor of family medicine; Dr. Ronald B. Mack, associate professor in the Section on Allied Health Programs; Dr. John C. Mueller, instructor in medicine; Dr. Otto Theodore Wendel, Jr., instructor in neurology (neuropharmacology); and Dr. Frank B. Wood, assistant professor of neurology (neuropsychology).

Those appointed to the part-time faculty were Gerald N. Hewitt, lecturer in hospital administration; Dr. Ralph A. Latham and Dr. Gary R. Smiley of

Chapel Hill, and Dr. William H. Claypoole of Durham, lecturers in plastic surgery (orthodontia-dentistry); Dr. William C. Ferguson, Dr. Ismael R. Goco, Dr. Keith R. Kookan, and Dr. Earl P. Welch, Jr., clinical instructors in surgery.

* * *

Dr. Richard Janeway, dean, has been appointed chairman of the Data Development Liaison Committee of the Association of American Medical Colleges.

* * *

Researchers at Bowman Gray have developed evidence of a heretofore undetected cause of hearing loss associated with deep sea diving.

Dr. James G. McCormick, research associate professor of otolaryngology, recently discovered air bubbles in the inner ears of guinea pigs which had undergone a simulated dive of 300 feet in a hyperbaric chamber.

It was the first time bubbles in the inner ear fluid have been reported, though hearing researchers have known for some time that air bubbles can occur in the circulatory system as a result of accelerated decompression from deep dives.

McCormick postulates that the bubbles can cause mechanical displacement of sensory cells in the inner ear, resulting in hearing loss. It also is possible that the bubbles add volume to the fluid in the ear, creating enough pressure to break the thin membrane

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WEIR M. TUCKER, M.D.

GEORGE S. FULTZ, JR., M.D.

GRAENUM R. SCHIFF, M.D.

that covers the round window in the inner ear.

McCormick was recently awarded a \$35,000 grant by the Office of Naval Research and the Naval Medical Research and Development Command to support further study of the discovery.

* * *

Eighty preceptors of the medical school attended a workshop March 21-22 in Winston-Salem. Sponsored by the Department of Community Medicine, the workshop was the first in a series designed to refine guidelines and educational objectives of the school's preceptorship program. Through the preceptorship program, medical students and physician assistant students receive part of their training in doctor's offices, clinics and small community hospitals across the state, with their work being supervised by practicing physicians who are participating in the program.

* *

Dr. James A. Chappell, associate professor of community medicine, has been named vice chairman of the Department of Community Medicine. He will assume the major responsibility within the department for the satellite clinics, Student Health Services, educational activities and the preceptorship program.

* * *

Dr. Robert W. Hamilton, assistant professor of medicine, has been appointed to the Board of Direc-

tors of the Kidney Foundation of Forsyth County, and to the Board of Trustees of the Kidney Foundation of North Carolina.

* * *

Dr. Donald M. Hayes, professor and chairman of the Department of Community Medicine, has been named a special consultant to the Chief of the Resources Branch of the Division of Cancer Control and Rehabilitation of the National Cancer Institute. He also has been appointed chairman of the North Carolina Task Force for Drug Education of the North Carolina Drug Authority.

* * *

Dr. David R. Mace, professor of family sociology, was awarded the Bell Award as "Man of the Year" by the Forsyth Mental Health Association during its annual meeting.

* * *

Dr. C. Douglas Maynard, professor of radiology, has been elected to the Board of Regents of the American College of Nuclear Physicians.

* * *

Dr. Jesse H. Meredith, professor of surgery, has been appointed to the Committee on Traffic Safety of the North Carolina Medical Society.

* * *

Dr. Joseph E. Whitley, professor of radiology, has been reappointed to a one-year term as consultant

"WHEN YOUR BACK FEELS GOOD YOU'LL FEEL GOOD"

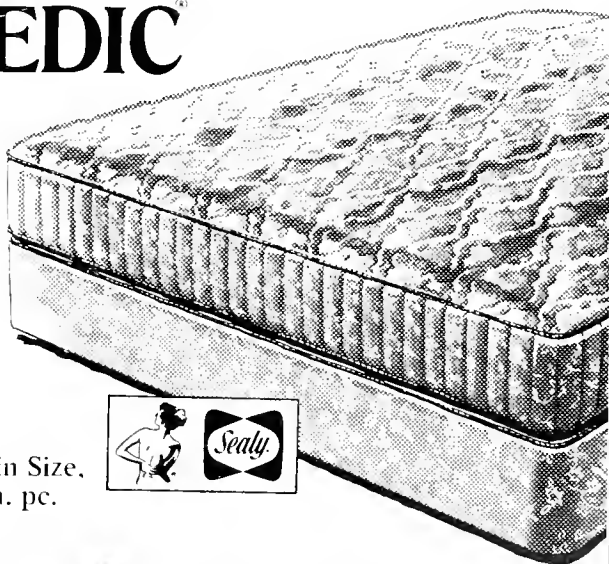
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with the Applied Neurologic Research Branch of the National Institute on Neurological Diseases and Stroke.

AMERICAN BOARD OF FAMILY PRACTICE

The American Board of Family Practice has announced that it will give its next two-day written certification examination on November 1-2, 1975. It will be held at five centers geographically distributed throughout the United States.

It is necessary that each physician desiring to take the examination file a completed application with the Board office. The deadline for receipt of applications in this office is June 15, 1975.

Information regarding the examination may be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex 2, Room 229, Lexington, Kentucky 40506.

AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology, a 6,000-member organization of cardiovascular scientists, has named nineteen of its Fellows to its Board of State or Area Governors. The new governors will be responsible for the activities of the College within their region.

Of those who will serve, from North Carolina is Robert E. Whalen, M.D., Durham.

AMERICAN COLLEGE OF RADIOLOGY

Three North Carolina physicians have been cited for distinguished achievements by being named a Fellow of the American College of Radiology. They are: Dr. Morris A. Jones, Jr., Durham; Dr. Irwin S. Johnsrude, Durham; and Dr. Joseph G. Gordon, Winston-Salem.

The College, a professional medical society representing more than 9,000 physicians who specialize in radiology, awarded them a Fellowship during its annual meeting and Convocation in Portland, Oregon, in April, 1975.

NORTH CAROLINA BLUE CROSS AND BLUE SHIELD

Elected to serve on the Blue Shield Committee by the North Carolina Medical Society's Executive Committee are: Drs. John W. Foust, Charlotte; David L. Kelly, Jr., Winston-Salem; George T.

Thornhill, Raleigh; and Robert L. Timmons, Greenville. Dr. Foust is on the attending staff of Charlotte Memorial, Mercy and Presbyterian hospitals; Dr. Kelly is an associate professor in neurosurgery at Bowman Gray School of Medicine; Dr. Thornhill is an ophthalmologist; and Dr. Timmons is a clinical professor of surgery at East Carolina School of Medicine.

Effective January 1, 1975, the following benefit changes became effective for the Federal Employee Program (FEP). The Low Option indemnity schedule for basic surgical-medical services has been increased 33.3 percent (excluding laboratory and x-ray fees and the \$175 allowance for total normal maternity care). Dollar limitations on Basic Low Option maternity hospital benefits have been eliminated; regular Basic hospital benefits now apply. The physician's Basic \$175 allowance for maternity care is not affected. The 14-day limit per admission on intensive in-hospital medical care has been eliminated. Basic surgical-medical benefits are provided for medically necessary intensive in-hospital physician care for up to 365 days under High Option and 90 days under Low Option.

James D. Webb and Larry W. Moss have joined the Plan's Blue Shield Activities Division as Professional Relations representatives in Greensboro and Raleigh, respectively. Webb serves the newly designated West Central Region comprised of Alamance, Caswell, Chatham, Guilford, Randolph and Rockingham counties. Moss serves Durham, Franklin, Granville, Johnson, Orange, Person, Vance, Wake and Warren counties.

Blue Cross and Blue Shield of North Carolina has received permission from the North Carolina Insurance Department to market catastrophic major medical coverage with benefits up to \$250,000 for each participant. The new catastrophic benefits are now being marketed to enrolled and prospective groups. The Plan's trustees decided to offer the catastrophic benefits in response to a 1973 public opinion survey which showed that fear of incurring a sizeable debt due to a catastrophic illness or accident is a major concern to North Carolinians.

Dr. Hugh B Lofland, Jr., 53, professor of pathology and co-director of the Specialized Center of Research (SCOR) in arteriosclerosis at the Bowman Gray School of Medicine, died April 2, 1975 following a brief illness.

Month in Washington

March saw the American Medical Association (AMA) testify a number of times before numerous Congressional committees on a number of bills, including professional liability, extension of health insurance to the unemployed, comprehensive elementary and secondary school health education, and air pollution.

The House Ways and Means Subcommittee on Health began hearings in consideration of legislation for sweeping studies of the medical professional liability problem. The measure, sponsored by Subcommittee Chairman Dan Rostenkowski (D-Ill.), authorizes a study by the Office of Technology Assessment in conjunction with the National Academy of Sciences.

Under the proposal, one study would be completed within 90 days and consider interim arrangements for solution of problems relating specifically to Medicare and liability. The second study, with a ten month schedule, would review the entire area of professional liability compensation.

In testimony before the Subcommittee, Malcolm Todd, M.D., AMA President, urged that remedial activity be undertaken at the state level. He told the Subcommittee that personal injury lawsuits are determined under the state rules of law and that the United States Constitution requires this procedure, "and as a consequence, each state can determine its own destiny and provide a wealth of experience—favorable or unfavorable—to its neighbors. Accordingly, the AMA is cooperating with our federated state societies in actively fostering discussion of professional liability law at the state level throughout America. We recognize that each state has its unique cultural, industrial, and social composition, and, accordingly, we expect to see a diverse response to the suggestions which we advance. However, we also expect to reap a rich experience by working within the system of American Federalism."

The AMA President said that the federal government can be of assistance, but the ultimate responsibility is upon the states, and "No one, least of all I suspect, within this Congress, wishes to see this situation deteriorate to such an extent that the federal government is required to intervene."

Dr. Todd urged specific language for the Professional Standards Review Organization program to avoid interpretation of the law as providing federal minimum standards of care, which, he warned, would drastically increase defensive medicine.

With respect to health insurance for the unemployed, Russell B. Roth, M.D., AMA's Immediate Past President, testified before the Rostenkowski subcommittee, that the current recession and inflation "have challenged the continued enjoyment of a way of life which we as a society so shortly ago assumed to be invulnerable." The medical profession, Dr. Roth said, is committed to the goal of "reducing the human suffering increasingly prevalent throughout society."

The plight of the unemployed calls for fast remedial action "to devise a method under which health coverage is continued for the unemployed individual and his family and to afford such protection without disruption to the health delivery system," he continued. Dr. Roth advocated a temporary program which would, during the period of unemployment, continue the worker's insurance coverage for himself and his family. Such a program should be built upon the existing unemployment compensation system, one which affords a ready mechanism for implementation of a temporary program, according to Dr. Roth. While the program would be funded from the general revenues of the federal government, premiums would be paid on the basis of certification of entitlement by state unemployment compensation agencies, he said.

A simple extension to the unemployed of Medicare Part A insurance coverage under the Medicare program would restrict the benefits to hospital care and any proposal which would condition the payment for services upon a hospital admission could only be expected to increase pressure for utilization of expensive care facilities and further aggravate inflationary costs, according to Dr. Roth. "Moreover," he said, "the administration of a temporary health insurance program through the enlistment of the Medicare bureaucracy would place an immediate and intolerable burden upon an already strained bureaucracy."

The AMA presented similar testimony to the Senate Health Subcommittee, headed by Senator Edward Kennedy (D-Mass.), which is holding hearings on the same subject.

* * *

The AMA has asked Congress to approve legislation to encourage comprehensive elementary and secondary school health education programs through a system of grants for teacher training, pilot and demonstration projects.

"The unfortunate fact is that most children and

youths of the nation do not now have an opportunity to participate in comprehensive health education programs, since health education in many schools either is non-existent or is provided on a fragmented and inadequate basis," said Joe T. Nelson, M.D., a member of the AMA Board of Trustees.

Dr. Nelson told the House Education and Labor Committee, "The Comprehensive School Health Education Act can help build into the primary and secondary education of every American child a program of health instruction that will help establish patterns of living that we know will discourage disease and enhance health."

* * *

Research on air pollution has proved that there can be health effects from long-term, low-level exposure, the AMA has told Congress. Episodes affecting large populations occur. Persons at high risk suffer more during periods of high pollution, and children may carry effects into adult life, William Barclay, M.D., AMA Deputy Executive Vice President, testified.

Dr. Barclay told the House Health Subcommittee that the AMA House of Delegates has endorsed the present levels and time schedules promulgated by the Clean Air Act-1970, and encourages Congress to preserve present levels and time schedules as necessary public health measures.

* * *

Elsewhere on the Hill the House Health Subcommittee has approved a health manpower bill authorizing \$1.7 billion over three years to support medical and other health profession education. Under the proposal similar to the House-passed bill last year, medical schools would receive capitation support of \$2,100 for each student for 1976 and 1977, with support decreasing to \$2,000 per student in 1978. The bill provides a simple extension of present health manpower authority for this year.

Medical schools would be required to either increase their enrollment or provide for remote site training for at least 50 percent of their students in their last two years of medical school education. Medical students would be required to pay back to the United States Treasury, capitation amounts paid to schools on their behalf, but would be given capitation payback forgiveness, on an equal year-for-year basis, for time spent in the National Health Service Corps or service in private practice in medically underserved areas.

Approved medical residencies could not exceed 155 percent of the previous year's graduating class starting in 1978 as a restriction on foreign medical graduates. In 1979 and 1980, limitation would decrease to 140 percent and 125 percent. The Coordinating Council on Medical Education could administer the residency limitation, but if it does not agree to accept such administration, the government would do so.

Designated as primary care specialties would be General and Internal Medicine, Pediatric Medicine,

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

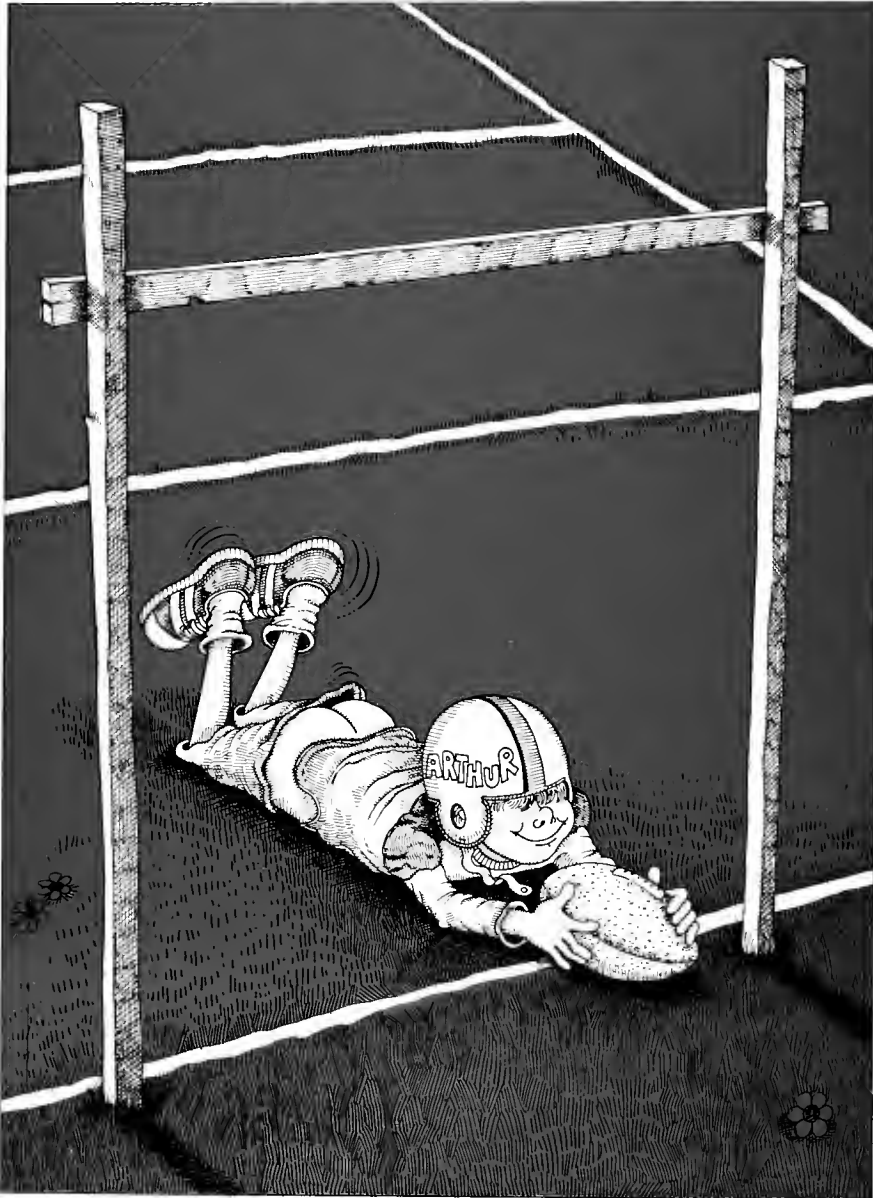
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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VOL. 36, No. 5

WORMS BLITZED



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Family Medicine, and Obstetrics and Gynecology.

Senator Edward Kennedy (D-Mass.) has introduced four bills dealing with health manpower, including his sweeping plan of last year calling for mandatory service and licensing and re-licensing. This was rejected in the last Congress by the Senate in favor of Senator J. Glenn Beall's (R-Md.) more limited plan. House and Senate could not reach agreement on the legislation last year. Kennedy's health subcommittee will hold hearings on the four bills in a month or so.

* * *

Despite President Ford's flat declaration that he would not introduce a national health insurance (NHI) proposal in the first session of the 94th Congress and would veto any such proposal, there is still talk of NHI this year by the Democratic leadership in both House and Senate.

During Dr. Russell Roth's testimony before Representative Dan Rostenkowski's Ways and Means Health Subcommittee on health insurance for the unemployed, the Chicago Democrat said: "Whatever program (unemployed health insurance) may be enacted by Congress, we can expect that it will last until national health insurance goes into effect. The bills which have been introduced so far would phase out in a year or so. But as practical people, we know that any program we adopt will not be allowed to lapse until a permanent solution under national

health insurance is in place. If we start a program with unemployment at nine percent, we will not be able to phase it out should unemployment levels drop to four percent—a figure we have not had in a long time. A program benefiting millions of people could hardly be arbitrarily cut off."

When his Subcommittee completes its work on the emergency problem, it will consider national health insurance. "The fact that we must do something about the immediate problem illustrates clearly the need to fashion a sound, workable plan of national health insurance for the long run. Beginning next month, this Subcommittee will be working long hours to meet that goal," Rostenkowski said.

HEW Secretary Caspar W. Weinberger has announced that the effective date for implementation of the utilization review regulations in hospitals and other health care facilities participating in the Medicare and Medicaid programs has been changed from February 1, 1975, to July 1, 1975.

"A number of questions about requirements and interpretation of the utilization review regulations have been raised since their publication, and some small rural hospitals have expressed concern about their ability to conform to these regulations," the Secretary said. "We have decided to move the effective date of the regulations so as to allow all providers to come into full compliance and to avoid the loss of eligibility to participate in the Medicare and

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Medicaid programs before July 1," he added. Secretary Weinberger said the Department would also use the time to work out special problems that may be faced in small rural hospitals.

Facilities with small medical staffs, especially those in rural areas, may have difficulty organizing the in-house review committees to operate the review system required by the regulations, the Secretary said. "For these facilities, several alternative means of complying with the law are provided in the regulations. State survey agencies and Departmental personnel will be available to work with the small facilities on these alternatives so that they can develop review systems that comply with the regulations."

* * *

Health care spending in the United States climbed over \$100 billion for the first time in fiscal 1974, which ended last July 1. Public spending increased twice as fast as private spending.

A study, *National Health Expenditures*, published in a recent edition of the Social Security Bulletin, noted that the \$104.2 billion health care bill represented a 10.6 percent increase over the \$94.2 billion spent in fiscal 1973.

Public spending amounted to \$41.3 billion, or 39.6 percent of the 1974 total, an increase of 15.3 percent, or \$5.5 billion. Private spending—mainly private insurance and out-of-pocket payments—accounted for \$62.9 billion, or 60.4 percent of the total health care expenditures for 1974. This was up 7.7 percent, or \$4.5 billion, over fiscal 1973.

Despite the dollar increases, health spending remained at the 1973 proportion of gross national product—7.7 percent. Health spending averaged \$485 per person. Hospital care was the largest expenditure category, amounting to \$40.9 billion, or 39 percent of the total. Physicians' services accounted for \$19 billion, or 18 percent. Expenditures for nursing home care reached an estimated \$7.5 billion. Of all personal health care spending in 1974, the government accounted for 38 percent; private health insurance, 26 percent, philanthropic organizations, one percent; out-of-pocket spending accounted for the remaining 35 percent. Increases in Medicare and Medicaid expenditures accounted for most of the increase in the public share of health care expenditures.

* * *

The government has abandoned a long fight to classify high potency vitamins as drugs, bowing to opponents of vitamin legislation in Congress. Vitamin products will be available over-the-counter in any strength less than toxic, according to Food and Drug Administration (FDA) officials. The Agency had hoped to require drug classification for vitamins exceeding 150 percent of the recommended daily allowance. This and other proposed restrictions on vitamins had prompted a storm of protest to Congress from health food users and makers. The Senate last year voted 81 to 10 to prevent the FDA move. Court decisions had generally favored the FDA's right to impose restrictions on vitamin preparations, but the Agency recently decided to drop the hot potato.

Book Reviews

Handbook of Forensic Pathology. By Abdullah Fatteh, M.D. 349 pages. Price, \$22.00. Philadelphia, Pa.: J. B. Lippincott Co., 1973.

This book is primarily written for general pathologists and for medical examiners, who, according to the author, although only secondarily involved in forensic pathology, nevertheless are taking care of the bulk of the autopsy work during the medico-legal investigation of death.

Consisting of 349 pages with 157 illustrations, the book is divided into 23 chapters covering the major aspects of death due to trauma. The language is clear, the errors are few. The emphasis is on practical aspects of the forensic pathology with referrals to other sources for in-depth information.

The book should be useful for a beginning pathologist and for people involved in medico-legal investigations.

MODESTO SCHARYJ, M.D.

Heroin Addiction in Britain. By Horace Freeland Judson. 200 pages. Price, \$6.95. New York: Harcourt Brace Jovanovich, 1974.

To those who have been aware of the drug abuse "scene" during the past decade, the "British system" for managing heroin addiction has become legendary. Interestingly brought to light by Judson, there is no "system," and those who have extolled "its" virtues have been woefully ignorant.

This book clearly reveals too that there is an "American" and a "British" attitude toward heroin and heroin addiction. The American attitude is that heroin is categorically bad, only incidentally having the properties of an excellent analgesic. The British attitude is that heroin is an excellent analgesic whose use carries with it the unfortunate potential for addiction. The logical extensions of these attitudes are that heroin addicts in America are bad or criminal, whereas those in Britain are neither good nor bad, but merely ill. The author examines these beliefs in detail and shows their influence on the management of heroin abuse in the two countries.

The first section reviews the history of heroin and its use in Britain from 1874 to 1968. Although this era was a long and sometimes stormy one, Judson points out that both the United States and the United Kingdom ended it with more questions than answers about heroin. This section appropriately closes with a quotation from Dr. Griffith Edwards:

"The touchstone for all our policies must be *cui bono*? For whose good do we legislate, criminalize, open another clinic, issue another report, mount another television spectacular, lecture at that class of school children, engage in all-out actions, hold to our assumptions?"

The second section is devoted to a review of research and practice presently conducted at English addiction-treatment clinics. Interestingly enough, no satisfactory data are available to support the British approach to heroin. The one clear difference is that they admit it freely while we Americans feel constrained to shout our beliefs about heroin to keep from admitting our own lack of data.

The third and final section has to do with the unfinished business of society in regard to heroin. Although few of the basic questions about heroin and modern society have been answered, one British physician remarked, "We have made it possible in this city for the addict to live without fear." One cannot help wishing Americans could say as much.

A glance at the price of this book (\$6.95) should be sufficient to show that it is not a "medical" publication. I cannot, therefore, recommend it on a medical basis. I do recommend it as a social commentary, provocatively written.

DONALD M. HAYES, M.D.

In Defense of the Body. By Roger Lewin. 146 pages. Price, \$2.50. New York, N. Y.: Doubleday & Co., Inc., 1974.

It is difficult to determine for whom this book is written since it reads more like a storybook than a scientific publication; yet the information is up-to-date and technical. The book is well written and covers the general field of immunology in an erudite fashion. The historical vignettes that relate to the discoveries associated with the progress in the field of immunology are particularly enjoyable. There is an excellent chapter on immunology of cancer and transplantation.

This paperback perhaps is a book in search of an audience. I would recommend it to undergraduate students interested in immunology, medical students, and to practicing physicians. I suspect that the lay public would be neutralized by the technicalities, whereas, I hope that the students of immunology will not be turned off by the somewhat folksy approach.

CHARLES E. MCCALL, M.D.

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The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY ☐ ☐ ☐ June 1975, Vol. 36, No. 6

NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Colposcopy Experience in a Community Hospital Indigent Service, Frederick G. Wiegand, M.D.; Shigella Outbreak in Amos Cottage, Hospital for Retarded Children, Flora Nowell Winfree, P.A., and Doris S. Kelsey, M.D.; Thrombosis of the Splenic Vein with Secondary Rupture of the Spleen, W. Grimes Byerly, M.D.

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Colposcopy Experience in A Community Hospital Indigent Service

Frederick G. Wiegand, M.D.

EARLY coitus, early and frequent childbearing, and increased incidence of venereal infections increase the incidence of cervical intraepithelial neoplasia in the indigent population. When Papanicolaou smears have suggested tumor, confirmation of diagnosis has usually been sought by cold knife conization, a procedure which usually requires general anesthesia and hospitalization and which may be complicated by hemorrhage, infection, cervical stenoses, infertility and cervical dystocia.¹⁻³

Since colposcopic evaluation might decrease the frequency of cold knife conization without increasing patient risk,^{4,5} decreased hospital usage and expenditures for indigent care could result and the complications of conization would be eliminated. Our experience with colposcopy suggests that it is an effective and economical measure.

MATERIAL AND METHODS

The Department of Obstetrics and Gynecology, Wake Memorial Hospital, through affiliation with the University of North Carolina Residency Training Program, con-

ducts the following clinics in conjunction with the Wake County Health Department: Family Planning, Venereal Disease Control, Papanicolaou Screening Clinic, Abortion Clinic, Gynecology Clinic and Obstetrical Clinic. The women studied attended clinics for treatment or counseling and had routine Papanicolaou smears; those whose smears suggested tumor were referred to the hospital's Colposcopy Clinic for confirmation. Smears were reported as follows: (1) non-neoplastic, (2) suggestive of mild, moderate or severe dysplasia, (3) suggestive of carcinoma *in situ*, and (4) suggestive of invasive carcinoma. Immediately after the second smear was taken, the cervix was sponged with acetic acid solution and colposcopic examination was carried out. Since squamous cell neoplasms arise from the transformation zone and are of unicentric origin,⁶⁻⁸ it was imperative that the entire lesion be visualized and that it not extend into the endocervical canal. Under these circumstances, no other squamous cell carcinoma of this cervix should be present.

Lesions were described as: (1) "white epithelium," usually emphasized by the acetic acid, with the vascular pattern obscured by hyperkeratosis or parakeratosis, (2) "punctuation," an abnormality of

the vascular pattern, (3) "mosiac," a more extensive vascular abnormality, and (4) "vascular atypicality," the most malignant. A colposcopically directed biopsy from the area considered to be the most malignant was done and histological diagnoses compared to the results of the Papanicolaou smears. That the pathological diagnosis of the biopsy adequately explain the origin of the abnormal cells reported on the smear was imperative. An essential comparison was a variance of 1° of severity, i.e., a Papanicolaou smear report of moderate dysplasia could be expected to arise from a lesion shown by biopsy to be no more severe than severe dysplasia or no less severe than mild dysplasia; when the degree of variation was greater, it was probable that the biopsy had not been taken from the most neoplastic area. The patients were then grouped as follows:

Group I—Endocervical canal completely visualized and free of tumor, lesion completely visualized, most atypical area biopsied and smear report and biopsy report correlated within 1° of atypicality.

Group II—Location and extent of lesion determined as in Group I, but biopsy report and smear report not correlated.

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Group III—Endocervical canal not free of tumor or not completely visualized, or extent of lesion not completely determined.

Group IV—Pregnant patients whose lesions fulfilled criteria of Groups I, II or III.

The patients were treated or followed according to the above grouping. Definitive treatment consisted of removal or destruction of lesions by hysterectomy, cold knife conization, cryosurgery, electrocautery or excisional biopsy.

RESULTS

One-hundred twenty-five consecutive patients were studied, not all of whom could be evaluated thoroughly. Figure 1 shows the locations of lesions in 96 of the 125 patients: Type A lesions extended laterally from the transformation zone, and Type B presumably arose at the transformation zone, extending medially toward the internal os and at times involving it. The numbers and percentages of locations are shown in Table 1; Type A are more often benign, and the lesions nearer the os more malignant.

The correlation between the Papanicolaou smear and the biopsy could be evaluated in 108 patients (Table 2). There was complete correlation in 67 patients (62 percent) and within 1° of atypicality in 34 (31

Table 2
Smear & Biopsy Correlation
(108 Patients)

Complete correlation	67	62%	93%
Within 1° of atypicality	34	31%	
More than 1° of atypicality	7	7%	

percent). Thus in 93 percent of the patients, criteria for acceptability were met and the Papanicolaou smear accurately predicted the severity of the lesion. The remaining patients were re-evaluated.

The 76 patients in Group I were treated definitively, without further investigation; prophylactic hysterectomy was strongly recommended when practical. When further childbearing was desired, or when the patient did not want a hysterectomy, excisional biopsy, elec-

Table 3
Biopsy & Hysterectomy Correlation
(25 Patients)

Complete correlation	15	88%
Within 1° of atypicality	7	
More than 1° of atypicality	3	12%

trocautery, or cryosurgery, or a combination, was done. Forty-seven patients in this group were treated by cryosurgery, 25 by hysterectomy without conization, three by excisional biopsy, and one by electrocautery. Table 3 shows the correlation between the biopsy and the hysterectomy reports in these 25 patients. There were no cases of invasive carcinoma; there was complete correlation in 15, and within 1° of atypicality in seven. Thus the colposcopically directed biopsy accurately predicted the final diagnosis in 88 percent.

A lack of correlation between the biopsy and the smear in the seven patients in Group II prompted repeat examination. The problem was resolved in two patients when repeat biopsy showed adequate correlation. One patient refused further investigation and was lost to follow-up. Three underwent conization and four hysterectomy. In no patient was invasive carcinoma of the cervix found.

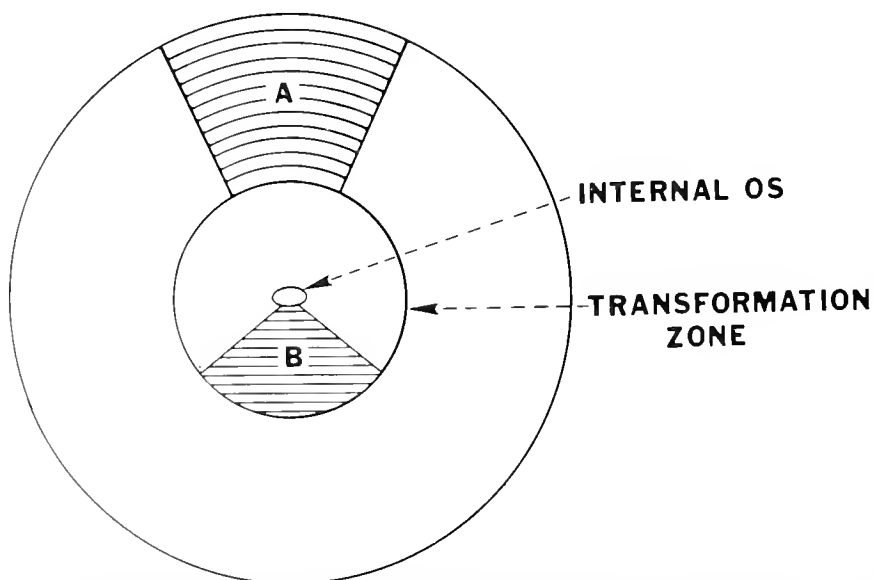
The 29 patients in Group III whose lesions could not be well delineated were subjected to cold knife conization. Five who had questionable involvement of the endocervical canal requested hysterectomy. After correlation of the Papanicolaou smear and biopsy, the lesion was located by colposcopic examination, and conization was performed with an immediate frozen section of the suspicious area. When there was no invasive cancer, vaginal hysterectomy was performed, thus avoiding double anesthesia or further hospitalization. Seventeen patients were treated by hysterectomy, nine others had conization, and one was observed because she refused treatment. Two patients who had obvious invasive cancer, proved by biopsy, were referred for definitive therapy.

The eight pregnant patients in

Table 1
Lesion Location
(96 Patients)

	A		B	
Mild	30	33%	11	12%
Moderate	19	20%	6	7%
Severe	2	2%	8	9%
CIS*	8	9%	12	13%
	59		37	

*CIS carcinoma in situ



Type A lesions, more often benign, extended laterally from transformation zone; Type B, possibly more malignant, arose at transformation zone and extended medially toward internal os.

Group IV presented special problems because conization during pregnancy can be hazardous^{4,9} and because hypertrophy of the cervix made visualization of the lesion difficult, but the endocervical canal was usually everted and could be more easily evaluated than in the non-pregnant state. The endocervical canal was usually found to be free of tumor. The patients were followed with colposcopic examination and Papanicolaou smears, and without conization, until delivery, after which they were re-evaluated and treated.

Before instituting colposcopic evaluation, conization would have been recommended for these patients. Assuming an average cost of \$350 per conization and an average stay of three days per patient, an expenditure by the county of \$43,750 and 375 hospital days would have been necessary. In this study, outlays included about \$3,000 for a colposcope, the expense involved in training the colposcopist, and the cost of the materials available in any pharmacy or gynecological examining room; 79.2 percent of conizations were avoided, with an estimated saving of \$34,650 and 297 hospital days.

COMMENT

If it were found to be as safe as, or safer, in excluding invasive cancer, colposcopic evaluation would be an acceptable substitute for cold knife

Patient	Smear	Biopsy	Frozen Cone*	Final Cone	Hysterectomy*
1	Moderate	Moderate	Mild	Mild	No Disease
2	CIS†	CIS	Severe	Severe	No Disease
3	Severe	Severe	Severe	Severe	No Disease
4	CIS†	Severe	Severe	Severe	No Disease
5	CIS†	CIS	Severe	CIS†	No Disease

*Frozen cone - hysterectomy under same anesthesia
†CIS - carcinoma in situ

conization. In this series, no patient undergoing hysterectomy had residual invasive cancer in the uterus. Of 17 patients who had conization prior to hysterectomy, ten had residual tumor in the uterus, confirming that cold knife conization does not always remove all tumor.^{3,10,11}

The use of a frozen cone followed by hysterectomy under the same anesthesia, the most controversial procedure in this study, was limited to patients in whom the endocervical canal appeared probably free of tumor. Table 4 shows the results of this treatment in five patients; no residual disease was found and all but one conization confirmed the presence of the suspected or less dangerous disease.

CONCLUSIONS

When a Papanicolaou smear is suggestive of disease, a definite lesion will be found in more than 90 percent of patients. Colposcopic evaluation of patients with such

smears is as satisfactory as routine conization when carried out correctly. Its use should result in an 80 percent reduction of conizations, monetary savings, decreased hospital bed usage, and avoidance of surgical complications.

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"Are you going to fit your ward for general practice or for a specialty?"

"I don't know, that'll be for the young person herself to decide," said Dr. Leslie good-humoredly. "But she's showing a real talent for medical matters. It is quite unconscious for the most part, but I find that she understands a good deal already, and she sat here all the afternoon last week with one of my old medical dictionaries. I couldn't help looking over her shoulder as I went by, and she was reading about fevers, if you please, as if it were a story-book. I didn't think it was worth while to tell her we understood things better nowadays, and didn't think it best to bleed as much as old Dr. Rush recommended."—*A Country Doctor*, Sarah Orne Jewett, 1884, p 105.

Shigella Outbreak In Amos Cottage, Hospital For Retarded Children

Flora Nowell Winfree, P.A.,* and Doris S. Kelsey, M.D.

AN increase in the number of reported cases of shigellosis in North Carolina occurred in the last quarter of 1973¹; concomitantly, an outbreak of infection with *Shigella sonnei* developed in Amos Cottage, a 40-bed hospital for developmentally-handicapped children, affiliated with Bowman Gray School of Medicine in Winston-Salem, North Carolina. The average inpatient census is 38, and day therapy is provided for an additional ten to 18 children. The staff of 62 includes a physician, a physician's assistant, 11 nurses and support personnel. Prior to the Shigella epidemic, frequent culturing, processed by the bacteriology laboratory of the North Carolina Baptist Hospital or the Forsyth County Health Department, had proved that Shigella infection was not endemic in this facility. At the time of the initial Shigella infections there was an outbreak of varicella. Four patients had both diseases simultaneously.

S. sonnei OUTBREAK

Twenty patients ranging in age from ten months to 14 years de-

veloped shigellosis during four months. Apparently the index case was a child returning from a therapeutic visit home where his family had a febrile illness with diarrhea. On return to the cottage the child was symptomatic, and a stool culture was positive for *S. sonnei*. Five children developed shigellosis the following week, and a total of thirteen cases occurred during an eight week period. Subsequently, almost a month elapsed without further cases, after which seven additional cases developed during three weeks. Nineteen children had febrile illness with diarrhea, but only three had severe diarrhea with blood and mucus.

After receiving the first culture report of *S. sonnei* infection, all patients with suspected infections were placed in enteric isolation, confined to a room with an adjoining bath, and not permitted to leave the area until stool cultures were free of Shigella for three consecutive days. Aides caring for these patients were not assigned to children who were not infected, and laundry of infected patients was handled separately from that of the rest of the hospital. Patients received extra liquids and symptomatic treatment for fever over 101 F. Opportunity for play

was available in the isolation room, but was not taken advantage of in most instances because isolation was more troublesome to patients than the disease.

On the twenty-first day of the outbreak, the 62 staff members, 11 day-therapy patients and 36 inpatients had stools cultured. The staff and day therapy patients had negative cultures; of inpatients, six were positive for *S. sonnei*; two of the six had developed symptoms prior to the receipt of the culture report; two were already in isolation; and two were asymptomatic, one of whom had recently been released from isolation after three negative cultures for Shigella.

The twenty patients were treated with ampicillin in a dosage of 100 mg/kg/day orally pending the results of culture and sensitivity. Eleven children with ampicillin sensitive strains had relapse or re-infection after one week of oral ampicillin; most of these occurred within a few days of cessation of treatment. *S. sonnei* was reported sensitive to ampicillin by disc sensitivity until near the end of the fourth month of the outbreak. The last three isolates were ampicillin resistant; since these children were not seriously ill, antibiotic therapy was discontinued

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From Amos Cottage, and the Department of Pediatrics, Bowman Gray School of Medicine, Winston-Salem, North Carolina 27103 (Dr. Kelsey).

Reprint requests to Dr. Kelsey.

upon receipt of laboratory reports. After recovery, five children excreted organisms for less than three weeks, eleven for approximately four weeks and four for two months or longer. Since most of the Amos Cottage children remain there for only two to three months, long-term follow-up was not done.

COMMENT

Shigellosis in custodial institutions is an important reservoir of endemic infection in the United States. The difficulty of controlling epidemics in large institutions with antibiotics and isolation is widely recognized and has prompted recent trials of *Shigella* vaccine.² Although most patients infected with shigellae do not excrete the organism for more than a month, in a recent study six to seven percent of

children shed the organism intermittently for a year, but the possibility of reinfection could not be excluded. Despite reports that asymptomatic carriers excrete few organisms, shigellosis differs from other enteric infections in that a small number of organisms can cause infection. Long-term carrier states (more than a year) have not been well documented since the introduction of antibiotics.³

S sonnei is the predominant organism causing *Shigella* infection in the United States today. *S flexneri* and *S sonnei* were equally responsible for cases of shigellosis during the early 1960s, but since 1969, there has been an increasing incidence of *S sonnei* infection.⁴ Emergence of organisms resistant to antibiotics has been an increasing problem.

SUMMARY

This brief report, describing an outbreak of shigellosis in a small hospital for developmentally-handicapped children in North Carolina, emphasizes the difficulties in eradicating *Shigella* from child-caring institutions.

ACKNOWLEDGMENT

We would like to thank Dr. Alan Hinman for his cooperation and assistance throughout the study, and Dr. Jimmy L. Simon for review of the manuscript.

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"I suppose the poor fellow who chipped out these treasures of yours may have thought they were really putting a visible piece of Heaven within their neighbors' reach," he said. "We can't get used to the fact that whatever truly belongs to the next world is not visible in this, and that there is idol-making and worshipping forever going on. When we let ourselves forget to educate our faith and our spiritual intellects, and lose sight of our relation and dependence upon the highest informing strength, we are trying to move our machinery by some inferior motive power. We worship our tools and beg success of them instead of remembering that we are all apprentices to the great Master of our own and every man's craft. It is the great ideas of our work that we need, and the laws of its truths. We shall be more intelligent by and by about making the best of ourselves; our possibilities are infinitely beyond what most people can dream. Spiritual laziness and physical laziness together keep us just this side of sound sleep most of the time."—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 111-112.

Thrombosis of the Splenic Vein With Secondary Rupture of the Spleen

W. Grimes Byerly, M.D., F.A.C.S.*

BLAUSTEIN has stated, "The normal spleen has never been reported to rupture spontaneously; consequently, rupture in non-traumatic cases must be regarded as due to underlying disease."¹ Because mortality in isolated splenic rupture is about ten percent and 15 to 25 percent when associated with other pathological events, early recognition and prompt therapy are mandatory.² The challenge of non-traumatic rupture of an apparently normal spleen, therefore, is one of diagnosis, rather than of treatment.

An illustrative case report of spontaneous rupture of the spleen secondary to acute passive hyperemia of the spleen due to acute idiopathic thrombosis of the splenic vein follows.

CASE REPORT

A 54-year-old white man, complaining of severe upper abdominal pain and lower anterior chest pain of 12 hours' duration, was admitted to the hospital October 16, 1973. Several days previously vomiting, progressing to retching, had begun. The patient previously had had an inguinal herniorrhaphy, an appendectomy and an umbilical herniorrhaphy. Three years earlier, dia-

betes was diagnosed but had been well-controlled with oral medication; he also had mild untreated hypertension and a history of heavy alcohol intake, but denied the use of alcohol during the past year. The patient had lost approximately 25 pounds by dieting. The history did not suggest trauma.

On physical examination the patient was desperately ill, mentally lethargic but responsive. His lips were cyanotic, and his breathing labored, with a respiratory rate of 40 per minute. The blood pressure was 160/80 and pulse rate was 110. Heart sounds were of good quality but irregular, with frequent PVCs. His lungs were clear, the abdomen obese but soft and nontender; bowel sounds were absent. An umbilical hernia was reducible and nontender. There was a peculiar lividity of the skin along the patient's right loin and right upper thigh. The remainder of his physical examination was within normal limits.

Laboratory studies showed: hemoglobin, 17.6 g; hematocrit, 53 volumes percent; white blood cell count (WBC), 15,368 mm³, with 80 percent polymorphs, two percent bands, 17 percent lymphocytes, and one percent monocytes. Urinalysis: specific gravity, 1.013; 2+ protein; no glucose; 1+ acetone; no bilirubin; microscopic, three to four

white cells, five to seven red cells; and five to seven hyaline casts per high power field. The blood sugar was 237 mg/dl; the blood urea nitrogen (BUN), 60 mg/dl; and serum sodium, potassium and chloride normal. The CO₂ was 4 mEq/l and was unchanged two hours later. The serum glutamic oxaloacetic transaminase (SGOT), lactic dehydrogenase (LDH), and creatinine phosphokinase (CPK) were markedly elevated. Serum and urine amylase and lipase values, prothrombin time and the salicylate level were normal. Roentgenograms of the chest and abdomen were unrevealing. An electrocardiogram showed nonspecific T wave peaking, left ventricular hypertrophy and sinus tachycardia. A blood culture showed no growth.

On admission, working diagnoses of myocardial infarction, diabetic acidosis and sepsis were made. After admission the patient's blood pressure rose to 210 systolic, and then fell precipitously to 90 systolic and had to be maintained with metaraminol bitartrate (Aramine®) intravenously. Eight hours after admission his WBC had risen to 26,662 mm³. The arterial PO₂ was 120 mm Hg; PCO₂, 13.9 mm Hg; and pH, 6.9. The serum acetone titer was 1:2.

Twenty-four hours after admis-

*Chief of Surgery, Hickory Memorial Hospital, Hickory, North Carolina 28601

sion the hemoglobin was 13.4 g, the hematocrit was 37 volumes percent, the WBC was 24,692 mm³ with 84 percent polymorphs, eight percent bands, four percent lymphocytes, four percent monocytes and toxic granulations were in the neutrophils. The BUN had risen to 80 mg/dl, potassium concentration had fallen to 3.6 mEq/l, serum sodium and chloride concentrations were normal, but the CO₂ had risen to 11 mEq/l. The SGOT, LDH and CPK continued to be elevated. During this time the patient was given insulin, digitalis, ampicillin, sodium bicarbonate, electrolyte solutions and dexamethasone (Decadron®).

Approximately 36 hours after admission, the hemoglobin level dropped unexpectedly to 4.8 g, and hematocrit to 14 volumes percent. Coagulation was normal, the urine output remained satisfactory and blood pressure had stabilized in the normal range without the administration of vasopressors. The patient had developed peripheral edema and his abdomen had become more distended and diffusely tender without rigidity. Peristalsis had a tinkling quality with high-pitched rushes, and roentgenograms suggested a small bowel obstruction.

The patient then underwent abdominal exploration, with a preoperative diagnosis of probable mesenteric artery thrombosis. The anesthesia was intravenously administered pentothal with endotracheal nitrous oxide, oxygen and penthrane. A mid-abdominal ventral incision was made, and a hemoperitoneum of approximately 2,000 ml was encountered. There were massive adhesions at the site of the recurrent umbilical hernia. The liver was normal in color, size, shape, position and consistency. Exploration of the peritoneal cavity revealed a massively enlarged, profusely bleeding spleen, approximately six to eight times normal size, on the surface of which could be felt multiple fissures. The splenic vein was distended, approximately 3 cm in diameter, and filled with recent organized thrombus. No other abnormalities were found. The umbilical hernia was repaired with the wound closure. Postopera-

tive diagnoses were: (1) idiopathic thrombosis of the splenic vein with passive splenic hyperemia, and spontaneous rupture of the spleen with massive hemoperitoneum; (2) multiple intraabdominal adhesions; and (3) recurrent umbilical hernia.

Postoperatively, the patient was given heparin because of the thrombosis. For 48 hours he was unresponsive and required mechanical respiratory assistance. By the fifth postoperative day the BUN had risen to 100 mg/dl and the creatinine clearance was 2.4 ml/min and the temperature, which had ranged between 102 to 103 F, had fallen to 99-100 F. The pulse rate slowed from 110 to 90 and respiratory rate from 40 to 30 per minute. He became more alert and oriented. The abdomen continued to be distended but nontender. On the seventh postoperative day the patient became nervous, tremulous, and emotionally unstable. This situation was reversed by oral doses of alcohol in small amounts. Heparin was stopped on the tenth postoperative day when ecchymoses involving the wound, thighs and hips developed. His recovery was slow, marred by lethargy and episodic confusion, but he could be discharged on the twenty-first hospital day.

On gross examination the spleen weighed 550 gm. The capsule was disrupted and there had been previous rupture. The splenic vein was markedly dilated and contained thrombotic material, and the accompanying artery appeared small and somewhat sclerotic. There was massive congestion of the stromal tissue and extravasation of blood. On microscopic examination, sections of the spleen showed severe congestion. The erythrocytes and lymphoid cells were normal. There was extensive extravasation of blood into the subcapsular regions. Sections of the splenic vein showed thrombosis characterized by early fibrinous deposits and lamellae of platelets. The blood vessel walls were generally thickened and the artery showed moderate atherosclerosis with calcification.

COMMENT

The causes of splenic rupture

may be divided into three main groups: (1) trauma with or without underlying disease; (2) preexisting disease resulting from infection, inflammation, neoplasia, hematologic or cardiovascular disorders; and (3) so-called spontaneous rupture of an apparently normal spleen.^{3,4} Preexisting disease, often difficult to diagnose, may alert the surgeon to the possibility of rupture, as with an enlarged malarial spleen or splenomegaly resulting from mononucleosis, sarcoidosis or leukemia.^{2,4}

Splenic pathology secondary to vascular disorders, passive congestion of the spleen, may result from right ventricular failure, cirrhosis of the liver, portal vein thrombosis, or splenic vein thrombosis. In these conditions the spleen may be secondarily involved because of increased portal pressure which results in hyperemia with sequestration and destruction of the circulating blood elements with pancytopenia (Banti's syndrome).² Congestive splenomegaly of extrahepatic origin has been described in association with stenosis, sclerosis, or cavernous transformation of the portal vein, and with thrombosis of the splenic vein.⁵ Splenic vein thrombosis may result from extrinsic inflammation or pressure (pancreatitis or tumor),⁶⁻⁸ or intrinsic inflammation, as in the primary thrombophlebitis (the thrombophlebitic tumor of Eppinger),⁹ or Frugoni's syndrome.¹⁰

Sutton et al¹¹, in reviewing the English literature between 1900 and 1968, found 53 cases of splenic vein thrombosis and added another of their own. Sixteen of the 54 cases had no known cause, and 33 exhibited splenomegaly. Neoplasia was found in 19 cases, pancreatitis in six, trauma in four, and miscellaneous causes accounted for the remaining nine cases. Pancytopenia was rarely observed, but upper gastrointestinal bleeding was frequent. Sex and age appeared to be unrelated.

In 1971 Yale and Crummy⁸ reported seven cases of splenic vein thrombosis resulting in bleeding from esophageal varices. In five cases thrombosis was secondary to

pancreatitis; in one, to tumor; and in another, to a portacaval shunt. Sutton et al¹¹ reported a series of 327 cases of portal thrombosis in which only four cases involved isolated splenic vein occlusion.

Splenic vein thrombosis may lead to an acute passive hyperemia with marked enlargement of the spleen (500 to 1,000 gm). The splenomegaly may develop soon after the thrombosis has occurred; the mechanism of rupture is thought to be due to weakening of the capsule and trabeculae of the spleen through infarction or hemorrhage. Subcap-

sular hematomas occur and give way under increased intraabdominal tension.

SUMMARY

Spontaneous rupture of an apparently normal spleen is a rare life-threatening event, particularly when it occurs secondary to acute passive hyperemia of the liver or to idiopathic thrombosis of the splenic vein. As shown in the case report, the problem is one of diagnosis, rather than of treatment, so that prompt, curative surgery can be done.

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"But seriously, I like your notion of her having come to this of her own accord. Most of us are grown in the shapes that society and family preferences and prejudice fasten us into, and don't find out until we are well toward middle life that we should have done a great deal better at something else. Our vocations are likely enough to be badly chosen, since few persons are fit to choose them for us, and we are at the most unreasonable stage of life when we choose them for ourselves. And what the Lord made some people for, nobody ever can understand, some of us are for use and more are for waste, like the flowers. I am in such a hurry to know what the next world is like that I can hardly wait to get to it. Good heavens! we live here in our familiar fashion, going at a jog-trot pace round our little circles, with only a friend or two to speak with who understand us, and a pipe and a jack-knife and a few books and some old clothes, and please ourselves by thinking we know the universe! Not a soul of us can tell what it is that sends word to our little fingers to move themselves back and forward."—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 105-106.

Editorial

COUNTRY DOCTOR I

One of the fondest of medical myths, lovingly cultivated, has been that of the country doctor—gracious, compassionate, tireless, aware intuitively of what troubled his patient and able, by discreet phrase and gentle prescription, to drive away the devils of disease and unhappiness. For such myths to endure, some truth must have gone into their construction, else their appeal would have vanished along with strychnine, sodium cocodylate and a thousand other lost drugs. For the myth informs many of our efforts to improve medical care, to do something about returning doctors to small towns, even to work to overcome the non-medical factors contributing to gulfs in perinatal mortality between races in our country. At times the myth encounters others, equally well and often better entrenched; for example, that centralized planning, listing explicit goals and money, can for certain provide the making of a better medicine for a deprived constituency. Often the arena becomes one where opinions do battle, words accumulate and people suffer. In North Carolina, a state of small communities,

of farmers, of blacks, of Indians, in short a land of great diversity, opinions must sometimes retreat before experiment and exigency if we are to serve our constituents. One approach lies in combining clinic and classroom, since the Flexner report the method of undergraduate and immediate post-graduate medical education, at many teaching centers, the way of Area Health Education Centers (AHEC) being developed through the University of North Carolina.

For those of us inadequately informed about AHEC, an excellent discussion of its purpose and direction is provided by Dr. Henry S. M. Uhl, director of the Asheville center, in the editorial "Reorienting Medical Education: A Reappraisal" in the September issue of *Hospital Practice*, which also contains a good article about the program.¹ The often trite adjective "exciting" can be rejuvenated and applied to a well-designed program. If any state is capable of bringing it off, let us hope we are.

Reference

- 1 "In Carolina, Teaching Centers Link Atlantic to Appalachians," *Medical Practice* pp. 169-190.

Emergency Medical Services



CATEGORIZATION OF HOSPITAL EMERGENCY CAPABILITIES A PROGRESS REPORT

Oscar P. Hampton, M.D., F.A.C.S.

This article cites the progress to date toward categorization of hospital emergency services (CHES) based on the 1971 guideline developed by the AMA, American College of Surgeons, American Academy of Orthopaedic Surgeons, American Society of Anesthesiologists, American Academy of Pediatrics and the NAS-NRC. A number of cities and states have made an attempt to categorize hospitals and have met with several stumbling blocks. Hospital administrators were identified as the most serious road-blocks to CHES. The article urges that hospitals,

and in particular, administrators, must recognize that CHES is coming, either voluntarily or by governmental imposition, and in fact, already the U.S. Department of Health, Education and Welfare has taken steps toward categorization of hospitals for treatment of heart disease, cancer, stroke and end-stage kidney disease. The most significant criticisms which have accrued to date are included in the article and include the impossibility of the majority of hospitals of ever achieving category I unless they are university type hospitals; the necessity for a helipad and of cardiopulmonary bypass equipment being available; and the need in categories II and III for positions to be available in the Emergency Department. Other criticisms include arguments pro and con regarding the necessity that blood be available in the Emergency Department,

and the lack of definitions of such terms as "available immediately" and "promptly." The author discusses each criticism, agreeing with some and disagreeing with others. The major thrust of the article is that the criteria were not meant to be "cast in bronze" but were intended to field tested with reports back to the AMA so that the criteria might be modified. The overall concept of CHES is strongly urged and no attempt

is being made to promulgate the current AMA criteria as the final word.

—Abstracted by Herbert J. Proctor, M.D.

From "Emergency Medicine Today," Vol. 4, No. 3, March, 1975, John M. Howard, M.D., Editor. Original article may be obtained from Commission on Emergency Medical Services, American Medical Association, 535 Dearborn Street, Chicago, Illinois 60610.

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WHAT? WHEN? WHERE? In Continuing Education

June 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

June 16-18

North Carolina Hospital Association Annual Meeting
Place: The Grove Park Inn, Asheville
For Information: Diane Turner, North Carolina Hospital Association, P. O. Box 10937, Raleigh 27605

June 19-21

22nd Annual Mountaintop Medical Assembly
Program: Guest lecturers include Dr. Thomas J. Cinque, Lansing, Michigan, Dr. Ralph J. Veenema, New York City, Dr. James W. Woods, UNC School of Medicine, Dr. Maurice K. Roskelley, Salt Lake City, Utah, and Dr. Gordon H. Deckert, Oklahoma City, Oklahoma

Credit: 12 hours
For Information: Clinton L. Border, M.D., 204 Depot Street, Waynesville 28786

June 20-22

New Advances in Diagnosis and Treatment of Pediatric Pulmonary Diseases
Place: Quail Roost Conference Center, Creedmoor
Registration: limited to 40 pediatricians, internists or family practitioners
Credit: 11 hours; AAFP approved
For Information: Alexander Spock, M.D., P. O. Box 2994, Duke University Medical Center, Durham 27710

July 3-5

Fifth Annual Sports Medicine Symposium
Place: Center for Continuing Education, Appalachian State University, Boone
Sponsor: Committee on Medical Aspects of Sports, North Carolina Medical Society
Fee: \$25; physician and spouse \$45
Credit: 7 hours; AAFP approved
For Information: Frank C. Wilson, M.D., Department of Orthopaedic Surgery, UNC School of Medicine, Chapel Hill 27514

July 14-19

Duke Medical Postgraduate Course
Place: Atlantis Lodge, Atlantic Beach
Fee: \$125
Credit: 30 hours; AAFP credit applied for
For Information: William J. DeMaria, M.D., Assistant Dean, Office of Continuing Medical Education, Duke University Medical Center, Durham 27710

July 20-25

Annual meeting of the Southern Obstetric and Gynecologic Seminar, Inc.
Place: Great Smokies Hilton Hotel, Asheville
Fee: Members, no fee; non-members, \$50
Credit: 21 hours
For Information: W. Otis Duck, M.D., Drawer F, Mars Hill 28754

July 21-26

Postgraduate Course in Radiology
Place: Atlantis Lodge, Atlantic Beach (near Morehead City)
Fee: \$150; designed for radiologists, but open to all physicians. Enrollment limited to 75
Credit: 30 hours
For Information: Robert McLelland, M.D., Department of Radiology, P. O. Box 3808, Duke University Medical Center, Durham 27710

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop
Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
Sponsors: Divisions of Continuing Education, Bowman Gray, Duke, and UNC Schools of Medicine, and the Medical College of South Carolina
Fee: \$100
Credit: 20 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 5-6

North Carolina Chapter of the American Academy of Pediatrics and The North Carolina Pediatric Society—Annual Meeting
Place: Blockade Runner, Wrightsville Beach
For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 12-13

1975 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery. Main emphases will be upon Trophoblastic Disease, Vulvar Malignancies, and Endometriosis. Invited guests include Dr. John Lewis, New York, Dr. George Morley, Ann Arbor, Michigan, and Dr. Hugh Shingleton, Birmingham, Alabama.
For Information: W. T. Creasman, M.D., Director, Gynecologic Oncology, Box 3079, Duke University Medical Center, Durham 27710

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September 12-13

North Carolina Association of Blood Bankers Annual Convention
Place: Sheraton Inn, Charlotte
For Information: Roy A. Weaver, M.D., President, P. O. Box 2000, Cape Fear Valley Hospital, Fayetteville 28302

September 12-14

Legislative Workshop: this institute will bring together members of the North Carolina Medical Society and persons from the legislative and executive branches of North Carolina state government, so that North Carolina physicians may gain a better understanding of the process of government

Place: Center for Continuing Education, Appalachian State University, Boone

Sponsors: North Carolina Medical Society and Smith Kline & French Laboratories

For Information: Stephen C. Morrisette, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 18-21

Invitational Assembly for Advanced Urology: Pediatric Urologic Problems

Place: Pinehurst Hotel and Country Club, Pinehurst

Fee: \$135

Credit: 18 hours

For Information: James F. Glenn, M.D., Division of Urology, Duke University Medical Center, Durham 27710

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital

Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists Annual Conference

Place: Benton Convention Center, Winston-Salem

Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education, scientific exhibits and a display of commercial equipment.

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103.

October 17-18

Seventh Annual Duke Symposium on Orofacial Anomalies

Credit: 12 hours; AAFP credit applied for

For Information: Raymond Massengill, M.D., Department of Surgery, P. O. Box 3523, Duke University Medical Center, Durham 27710

November 3-7

Current Concepts in Pediatric Radiology

Place: Pinehurst Hotel, Pinehurst

Program: There will be a systems oriented format covering Cardiopulmonary diseases on Monday, Gastro-intestinal diseases on Tuesday, Genito-urinary diseases on Wednesday and Musculo-skeletal diseases on Thursday, "with Friday left for miscellaneous disorders."

Credit: 25 hours

For Information: Robert McLelland, M.D., Radiology—Box 3808, Duke University Medical Center, Durham 27710

December 5-6

Endoscopy Workshop

Place: Berryhill Hall

Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine

Fee: \$75

For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514



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CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months. Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in CUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopical discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl) 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

 WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

ITEMS OF SPECIAL INTEREST

Annual Session CME Credit

Participation in three activities in conjunction with attendance at the 121st Annual Session of the North Carolina Medical Society may be counted toward meeting continuing medical education membership requirements up to the following maximums, based on the number of your contact hours of participation: general sessions, 6 hours; audio-visual program, 12 hours; Session on Family Practice, 1 hour.

November 3-8

Course in Laryngology and Bronchoesophagology

Program: Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

For Information: Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, Illinois 60612

Family Practice Examinations

The American Board of Family Practice Certification Examination

Place: "five centers geographically distributed throughout the United States"

Fee: Application \$50; examination \$300; deadline for receipt or applications is June 15, 1975

For Information: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Kentucky 40506

PROGRAMS IN CONTIGUOUS STATES

August 21-23

Three Days of Cardiology

Place: Hilton Head Inn, Hilton Head Island, S. C.

Sponsors: South Carolina Heart Association, in cooperation with the North Carolina Heart Association

Fee: Fellows, Associate Fellows and Members of the Council on Clinical Cardiology, \$100; non-members \$150

Credit: 10½ hours; AMA Category I; AAFP approved

For Information: George E. Stewart, Jr., American Heart Association, 44 East 23rd Street, New York, NY 10010

September 7-13

General Practice Review Course

Place: Mills Hyatt House Hotel, Charleston, South Carolina

Fee: \$150

Credit: 38½ hours AAFP credit

For Information: Dr. Vince Moseley, Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

October 20-21

Tennessee Valley Medical Assembly annual meeting

For Information: Clifton R. Cleaveland, M.D., Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association

Place: Miami Beach, Florida

For Information: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205

December 7-10

Structure-Function Correlations in Cardiovascular Disease

Place: Williamsburg Conference Center, Williamsburg, Virginia
 For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

**BOWMAN GRAY SCHOOL
OF MEDICINE
WAKE FOREST UNIVERSITY**

Five Bowman Gray faculty members have been promoted to the rank of professor. They are among 20 members of the faculty who received promotions effective July 1.

Those gaining the rank of professor are Dr. M. Robert Cooper, medicine; Dr. Henry Drexler, microbiology; Dr. Charles E. McCall, medicine; Dr. Thomas F. O'Brien Jr., medicine; and Dr. Richard B. Patterson, pediatrics.

Receiving promotions to associate professor are Dr. David M. Biddulph, anatomy; Dr. Robert L. Dixon, radiology; Dr. David L. Groves, microbiology; Dr. Eugene R. Heise, microbiology; Dr. Phillip M. Hutchins, physiology (biomedical engineering); Dr. John S. Kaufmann, medicine and pharmacology; Dr. William B. Lorentz, pediatrics; Dr. Jack M. Rogers, psychiatry; Dr. Robert A. Turner, medicine; and Dr. Duke B. Weeks, anesthesiology.

Promoted to the rank of assistant professor were Dr. Ronald L. Collins, medicine; Dr. Patrick Currie, urology; Dr. Carolyn B. Ferree, radiology; Dr. Don C. Jones, pathology (biochemistry); and Dr. Finley C. Watts, radiology (health physics).

Members of the part-time faculty who received promotions were Dr. George W. Holmes, clinical associate professor of orthopedics; Dr. Robert T. Chambers, clinical assistant professor of pediatrics; Dr. Charles G. Gunn Jr., clinical assistant professor of community medicine; Dr. Harold N. Jacklin, clinical assistant professor of ophthalmology; and Dr. Paul R. Kearns, clinical assistant professor of obstetrics and gynecology.

Also, Dr. Robert L. Means, clinical assistant professor of surgery; Dr. Robert E. Nolan, clinical assistant professor of surgery; Dr. Peter E. Parker, clinical assistant professor of surgery; and Dr. Kenneth V. Tyner, clinical assistant professor of surgery.

Two were named to emeritus status. They are Dr. Howard M. Starling, clinical associate professor emeritus of surgery, and Dr. Belmont A. Helsabeck, clinical assistant professor emeritus of ophthalmology.

* * *

Fourteen medical students at Bowman Gray have been elected to membership in Alpha Omega Alpha, national medical honor society.

Senior students who were tapped for membership were Everette H. Alsbrook of Sumter, S. C.; Theodore S. Anderson of Fernandina Beach, Fla.; Douglas R. Boyette of Kenly; J. P. Burnette of Farmville; Thomas M. Ginn of Lakeland, Fla.; Charles L. Spurr Jr. of Winston-Salem; Lynn B. Spees of Winston-Salem; John H. Tinga of Castle Hayne; Donald Wex-

ler of Winston-Salem; and Hal B. Woodall of Smithfield.

Elected from the junior class were James B. Atkinson of Sarasota, Fla.; Alan M. Berg of Van Nuys, Calif.; Sidney L. Gullledge of Raleigh; and Michael R. O'Neill of Valparaiso, Ind.

The newly elected members were inducted at the annual dinner of the North Carolina Beta Chapter of Alpha Omega Alpha.

* * *

Dr. William H. Boyce, professor of urology, has been selected to serve on the National Arthritis, Metabolism and Digestive Diseases Advisory Council of the National Institutes of Health.

* * *

Dr. James A. Harrill, professor of otolaryngology, was installed as president of the American Laryngological, Rhinological and Otolological Society, Inc. during the society's April meeting.

* * *

Dr. Richard Janeway, dean, has been appointed for a three-year term to the editorial board of the "Annals of Internal Medicine."

* * *

Dr. Charles E. McCreight, associate professor of anatomy, has been elected president of the Wake Forest University chapter of the Society of Sigma Xi.

* * *

Dr. I. Meschan, professor and chairman of the Department of Radiology, was made a Distinguished Fellow of the American College of Nuclear Medicine at an April meeting of the college in Orlando, Fla.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, has been appointed to the board of directors of the North Carolina Foundation for Mental Health Research, Inc.

News Notes from the—

**UNIVERSITY OF NORTH CAROLINA
DIVISION OF HEALTH AFFAIRS**

State and local planning, as related to the National Health Planning and Resources Development Act of 1974, signed into law by President Ford on Jan. 5, 1975, was examined April 24-26 at a national conference at UNC-Chapel Hill.

Sponsored by the UNC Division of Health Affairs, the conference featured distinguished speakers discussing issues, problems, legal implications and federal-state-local relationships under the law.

Dr. Ralph Boatman, director of the UNC Office of Continuing Education in Health Sciences, was conference director.

* * *

The International Fertility Research Program (IFRP) developed at UNC-Chapel Hill under the

United States Agency for International Development (AID) sponsorship, which was separated from the University effective Feb. 14, 1975, will continue its mission and worldwide services as a private, non-profit corporation.

Dr. Elton Kessell, director of the program, is president of the new corporation.

* * *

Dr. Richard L. Clark of the UNC School of Medicine, Chapel Hill, has been selected a Picker Scholar.

The Picker Foundation, established in 1947 to foster advances in radiology, awards between ten and fifteen \$40,000 four-year scholarships each year.

Dr. Clark, associate professor of radiology and director of the Diagnostic Radiology Research Laboratory, currently is investigating the microvascular system of the kidney. He hopes to learn more about the patterns of change that occur with the various diseases which result in chronic renal failure. This information will enable him to determine if some of these diseases might be caused by failure of the renal microvascular network. He is also studying the vascular changes that occur when the body rejects transplanted kidneys.

* * *

Dr. Norman A. Coulter of the UNC School of Medicine, Chapel Hill, has been named associate editor of the journal of the *American Society for Cybernetics*. The journal publishes articles related to the flow of information in political, social and biological systems.

Coulter is a professor of biomedical engineering and mathematics. Before coming to UNC ten years ago, he was in the department of physiology and biophysics at Ohio State University.

* * *

Dr. Peter J. K. Starek, assistant professor of cardiothoracic surgery at the UNC School of Medicine, Chapel Hill, has been chosen a member of the Society of Thoracic Surgeons, which gives young chest surgeons throughout the country an opportunity to present results of their research at its annual scientific meeting.

* * *

Dr. Arthur J. Prange, Jr., professor of psychiatry at the UNC School of Medicine, Chapel Hill, was co-chairman on the 65th annual meeting of the American Psychopathological Association in New York City, March 6-7.

Dr. Prange and Dr. Morris A. Lipton, professor of psychiatry and director of the Biological Sciences Research Center at the University, presented papers at the meeting.

* * *

Dr. Colin G. Thomas, Jr., professor and chairman of surgery at the UNC School of Medicine, Chapel Hill, participated in the University of Mississippi's second annual Postgraduate Surgical Forum, March 13-15.

He presented two papers on the thyroid, "The

Thyroid Nodule" and "Current Practices in the Management of Hyperthyroidism."

* * *

Dr. C. Arden Miller of UNC-Chapel Hill has been appointed to an advisory panel of the Committee on Ways and Means' subcommittee on health. Dr. Miller, professor of maternal and child health in UNC's School of Public Health, and other members of the advisory panel will join the subcommittee discussions on national health insurance.

* * *

Promoted to assistant professor in the School of Medicine are: Drs. Lamar E. V. Ekbladh, Mary Susan K. Fulghum, Guy Photopoulos and Leslie A. Walton, all in the department of obstetrics and gynecology.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Josephine Newell, a private medical practitioner in Bailey, N. C., for the past 24 years, has been appointed coordinator of Duke's Breast Cancer Demonstration Project.

She succeeds Dr. F. M. Simmons Patterson who left to direct an Area Health Education Center in Greenville.

* * *

Dr. Daniel C. Tosteson, chairman of the Department of Physiology and Pharmacology, has accepted appointment as dean of the Division of the Biological Sciences and the Pritzker School of Medicine at the University of Chicago.

He also was appointed the Lowell T. Coggeshall Professor of Medical Sciences in the Department of Pharmacological and Physiological Sciences.

The appointments are effective July 1. Tosteson plans to assume his duties there full-time later in the year.

Tosteson came to Duke as department chairman in 1961. In 1971 he was appointed James B. Duke Professor of Physiology. He is a native of Wisconsin and a 1949 graduate of the Harvard Medical School.

* * *

Dr. George L. Maddox has been named a charter member of the federal government's National Advisory Council on Aging.

Maddox is a professor of medical sociology and director of the Center for the Study of Aging and Human Development here. He has written three books and numerous articles on the subject of aging.

His appointment was announced by Caspar W. Weinberger, U. S. Secretary of Health, Education and Welfare.

Weinberger's office said the new council's 12 members will advise the secretary on programs for the aged. Members will also help government health leaders decide which research grants to approve in the area of aging.

Dr. J. Lamar Callaway, chairman of the division of dermatology, was among three distinguished Duke alumni initiated into Phi Beta Kappa.

Also initiated into the society were Dr. John T. Caldwell, chancellor of N. C. State University, Dr. Raven I. McDavid, professor of English and linguistics at the University of Chicago, and 39 Duke undergraduates.

Callaway earned his bachelor's degree at the University of Alabama, and the M.D. at Duke in 1932. A James B. Duke professor, he has been on the staff of the School of Medicine since 1937 and has been chairman of dermatology since 1946.

* * *

Dr. J. David Robertson, chairman of the Department of Anatomy and a pioneer in high resolution electron microscopy, is one of three faculty members recently named to James B. Duke Professorships, the highest academic honor which Duke bestows.

Also named to the chairs were Dr. John H. Hallowell, noted in political science for his analysis of modern political ideologies, and Dr. Arthur Larson, a leading authority on workmen's compensation laws and social security.

Robertson is a specialist in cell membrane structure whose application of electron microscopy in this field has advanced the understanding of cell properties and functions.

The Asheville School— one of the two “names to consider” in the South.

That's how **Business Week** talked about us. We're often compared with New England prep schools... and not just because of our rambling mountain campus and ivy covered buildings.

Here at The Asheville School, we place the emphasis on getting into the more selective colleges. From 9th thru 12th grades, we stress the development of study habits that permit our graduates to get higher grades... particularly as college freshmen. This is increasingly important today in gaining acceptance to graduate schools.

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Other strong points include single dormitory rooms for each student, individually tailored study projects and an exciting mountaineering program. If you think your son ought to be college bound, write for more information. Even better, plan a visit to our campus.

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. Usage in Pregnancy: Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. Children and Adults: Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

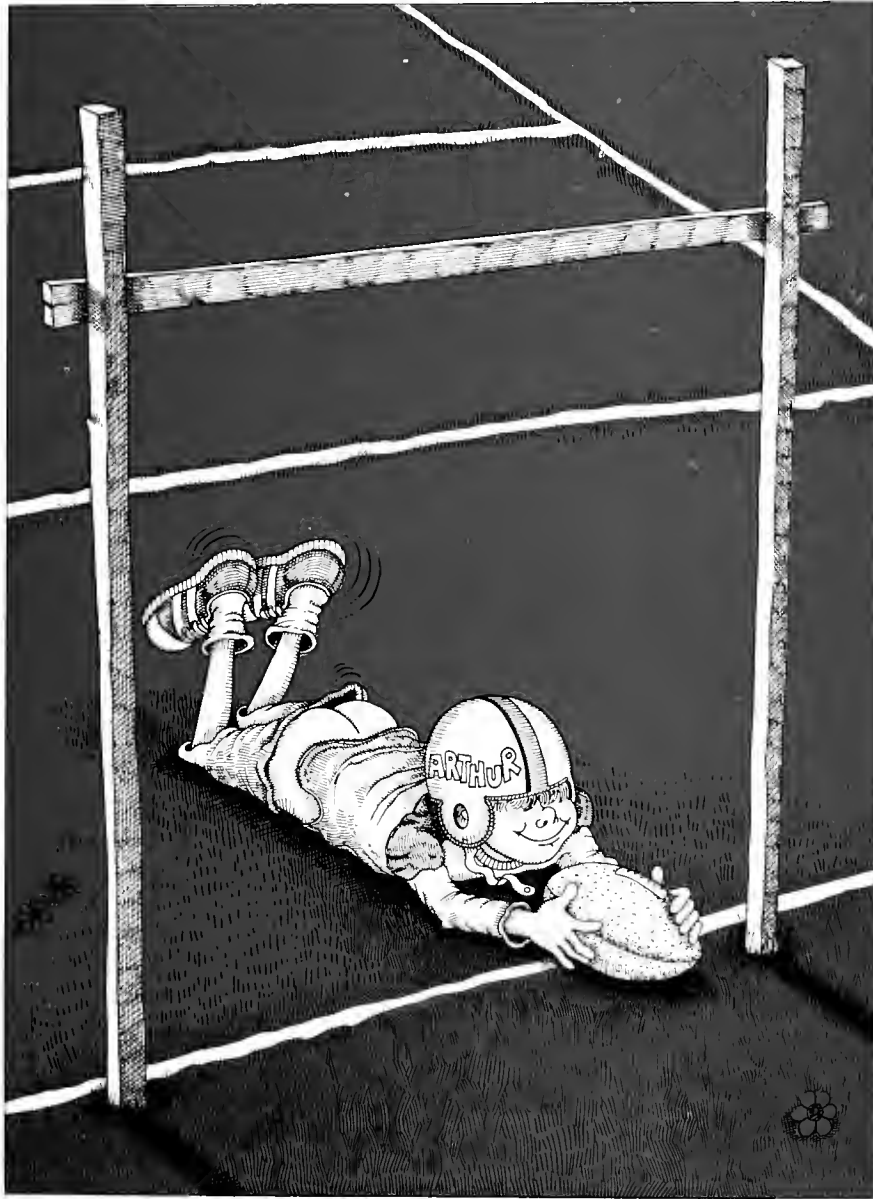
How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG 

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New York, New York 10017

VOL. 36, No. 6

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family

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**Pinworms, roundworms controlled
with a single, non-staining dose of
ANTIMINTH[®]
(pyrantel pamoate)**

equivalent to 50 mg. pyrantel/ml.
ORAL SUSPENSION

*Data on file at Roerig

Please see prescribing information on facing page

He came to the School of Medicine to chair the Department of Anatomy in 1966. A native of Alabama, Robertson received his undergraduate degree from the University of Alabama and his M.D. from Harvard in 1945. Prior to joining the Duke faculty, he was an associate professor of neuropathology and an associate biophysicist at McLean Hospital at Harvard Medical School.

* * *

Dr. Eric Pfeiffer, professor of psychiatry and associate director for programs at the Center for the Study of Aging and Human Development here, has been appointed chairman of the North Carolina Mental Health Council by Governor James Holshouser.

The 21-member council was created by the 1973 N. C. General Assembly to consider ways to promote mental health, study needs for new mental health legislation and advise the secretary of human resources.

Pfeiffer received his A.B. and M.D. degrees from Washington University in St. Louis, Mo., and has been on the Duke faculty since 1966.

He is a former chairman of the N. C. Mental Health Council, vice-chairman of the Medical Advisory Committee to the North Carolina Board of Mental Health and current vice president of the Gerontological Society.

Other members of the council include physicians, nurses, educators, psychologists and representatives of the military, business and the prison system.

AMERICAN OCCUPATIONAL MEDICAL ASSOCIATION

Harold D. Belk, M.D., Winston-Salem, was recently named to the Board of Directors of the American Occupational Medical Association, an international organization of 3,800 physicians who provide health care for employees of private enterprises, governmental services and other organizations. Dr. Belk is one of five physicians elected to a three-year term on the Board.

Dr. Belk is medical director of the North Carolina Works of the Western Electric Company, and also holds an appointment as assistant clinical professor in the Department of Community Health Sciences at Duke University, and as preceptor in the Department of Community Health at Bowman Gray School of Medicine. He holds the M.D. degree from the Medical College of South Carolina, and the M.Sc. degree in occupational medicine from the Ohio State University.

AMERICAN PHILOSOPHICAL ASSOCIATION

The American Philosophical Association has established a Committee on Philosophy and Medicine which will develop special programs at meetings of the Association. In addition, this Committee will distribute a newsletter including bibliographical and pedagogical information, lists of persons actively interested in philosophy and medicine, announcements

of conferences, and other materials. Persons wishing to be on the Committee's mailing list should write, providing the following information: name, address, institutional affiliation, professional field, primary interests in philosophy and medicine (e.g., ethical issues in clinical medicine, epistemology of medicine), and any relevant teaching experience or plans. Enclose \$2.00 to cover mailing costs. Write to: Professor John Ladd, Committee on Philosophy and Medicine, Department of Philosophy, Brown University, Providence, Rhode Island 02912.

PROBLEM PREGNANCY COUNSELING

The ratio of out-of-wedlock births in North Carolina continues to climb. In 1972, it reached 14.1 percent of total births, compared to 9.3 percent in 1960. In 1972, 7,698 of the 12,535 out-of-wedlock babies were born to mothers in the 15-19 year age range. (Public Health Statistics, N. C. Dept. of Human Resources, March 4, 1974.)

Physicians share with social workers and other professionals an increasing concern in helping young women who are experiencing a problem pregnancy to be fully aware of all available alternatives and to realistically assess each choice in the light of their individual situations.

The complexities of a mature decision on abortion, keeping her baby, or planning adoption can pose an overwhelming responsibility for a teenage girl and for older women. This decision significantly affects not only the pregnant girl and her unborn child but society at large. Problem pregnancies are a community concern. For example, pregnancy is the major cause of female school drop-outs in the United States.

A statewide resource for experienced problem pregnancy counseling is the Children's Home Society. Throughout a number of years, the medical profession and the Society have worked cooperatively in this area of service, in the firm conviction that each young woman be afforded the opportunity of being thoroughly knowledgeable of all options and of available resources for whatever decision she makes.

Partially-supported through United Funds, Children's Home Society offers skilled counseling, without charge, in all 100 counties. Through offices located in seven North Carolina communities, the Society provides a professional staff who are experienced in helping a young woman weigh the alternatives according to her own circumstances. The staff can assist the young woman in carefully considering the medical, emotional, financial and legal factors involved in each alternative choice, and in practical planning for the decision she makes. Counseling is also available to the young woman's parents and to the baby's father.

For the young woman choosing to continue the pregnancy, services include assistance in planning living arrangements during pregnancy, temporary care for the baby while the mother is reaching a decision about his future and, if requested, home-finding and adoptive placement for the baby. Many of the 2,010

couples, both black and white, coming to the Society in 1973 seeking to adopt a child, showed considerable flexibility in accepting a child with physical problems, so the biological mother choosing adoption can feel assured of a wide choice of homes for her baby, whatever his special needs may be.

In the last two years, the Society has provided services to 968 women. During that same period, 337 infants came into the Society's care while their biological mother was deciding on the best plan for her child.

Doctors may refer a patient, or obtain brochures and further information by contacting the nearest CHS office: Asheville (252-0293), Chapel Hill

(929-4708), Charlotte (372-7170, Ext. 257), Fayetteville (483-8913), Greensboro (274-1538), Greenville (752-5847), Wilmington (763-9727).

NEWS NOTE

Theodore D. Scurletis, M.D., M.P.H., has accepted a position of professor of pediatrics at the University of Iowa School of Medicine in Des Moines. He was for many years director of the Crippled Children's Program with the Division of Health Services (formerly the State Board of Health), and at the time of his resignation was Chief, Office of Research and Development of the Division of Health Services.

Month in Washington

The American Medical Association (AMA) has introduced a new proposal for national health insurance into the United States Congress. Key lawmakers on both sides of the aisle in the House of Representatives are sponsors of the bill—HR 6222. It is the only substantially new approach to national health insurance (NHI) presented in the 94th Congress. Called the Comprehensive Health Care Insurance Act, the bill was introduced into the House by Reps. Richard Fulton, (D-Tenn.); Tim Lee Carter, (R-Ky.); John Duncan, (R-Tenn.); and John Murphy, (D-N.Y.).

The AMA's NHI plan builds on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 percent of the cost. Employees would not be compelled to participate. The self-employed as well as the non-employed could purchase 'qualified private' health insurance, through pools if needed, at a cost not more than 125 percent of the cost of group plans. They would have all or part of the premium paid for by the federal government depending upon their income tax liability.

Small businesses that find the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would be eliminated under the program.

After a certain level of co-insurance is reached, depending upon income, insurance covers all remaining costs as a complete protection against catastrophic costs. The co-insurance factor would deprive no one

of needed care, sponsors said. The maximum that anyone would have to pay would be \$1,500; the maximum for any family would be \$2,000 in any given year.

Fulton, a member of the House Ways and Means Committee, told the House that the bill "represents the evolution of the doctors' thinking on this complex subject; and it demonstrates that the continuing process of discussion and debate has influenced the doctors as, indeed, it has influenced the thinking of Congress."

"We must build on the structure of group health insurance which is today providing sound basic coverage for a vast majority of Americans at no cost to the government," said Fulton. "It is easier to remedy whatever deficiencies exist in this mechanism than to junk it in favor of a new and elaborate government structure that would have to be created from scratch . . . it would also be considerably less traumatic for Americans to remain with a familiar system. . . ."

Rep. John Duncan, third ranking Republican on the House Ways and Means Committee, said in a House speech that "the AMA plan does the best job to date in identifying the line between national bankruptcy and national parsimony in expenditures for national health insurance."

"The doctors' plan provides federal assistance on the basis of need. The most help goes to those who need it most. The least help goes to those who need it the least."

He said the Comprehensive Health Care Insurance Act removes the fear of catastrophic illness that plagues even well-off Americans and provides sweeping regular benefits, including 365 days of inpatient hospital care, 100 days of skilled nursing care, full

dental care for children, home health benefits and many other services including psychiatric treatment and well-baby care.

Rep. Tim Lee Carter, a physician-member of Congress and ranking minority member of the House Health Subcommittee, said the bill "retains a large measure of pluralism in the administration and financing . . . and it is precisely this pluralism—the creativity and sensitivity of the private sector, supplemented only where necessary by government—that has made the quality of American medicine hands-down the finest in the world."

Dr. Carter pointed to the cost control mechanism of "co-insurance" (except for the poor) in the physicians' plan. "There is incontestable evidence that any health care system without some regulatory control is soon bogged down by the 'worried-well,'" he said.

Rep. John Murphy of New York, a member of the Commerce Committee, said organized medicine's plan "does about what the federal government can afford to do at this particular time. It will not be legislation that overpromises and underperforms."

The lawmaker denied "that any form of national health insurance is preferable to what we have. The

right kind of program can accomplish much; the wrong kind could actually do harm."

"The need is immediate," declared Murphy. "Because the program utilizes the existing structure of the private insurance industry, there can be a fast start-up. There will be a minimum of administrative costs and bureaucratic delays.

"This is the place to start: a sound foundation of comprehensive health services, available to all Americans, and at a reasonable cost."

* * *

The AMA has told Congress that federal legislative remedies for the professional liability crisis could create a worse situation and in some cases result in even higher liability costs.

Testifying before the Senate Health Subcommittee headed by Sen. Edward Kennedy (D-Mass.) as it opened hearings on the liability issue, AMA President Malcolm C. Todd, M.D., declared "it is far wiser for states to enact varied innovative legislative responses to the problem than to have an untested and unproved scheme enacted on a nationwide basis by the federal government, particularly where such proposals contain elaborate provisions for federal government regu-



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lation of the practice of medicine."

Dr. Todd, accompanied by Richard E. Palmer, M.D., Chairman of the AMA Board of Trustees, said there's no question a crisis exists in medical liability insurance. "The complexity of the problem and its varied causes convince us, however, there is no single solution, be it arbitration, 'no-fault' or anything else."

Many states are acting on the liability problem, Dr. Todd pointed out. "Perhaps the eventual solution in most states will be a synthesis of various approaches. . . . Enactment of a federal program would eliminate the state's initiative and would establish a program that would fail to recognize individual state problems," he said.

One of the bills before the Subcommittee proposes compulsory arbitration tied to licensure and relicensure of physicians, review of all physicians' services by Professional Standards Review Organizations (PSRO's), acceptance of federal fee schedules under Medicare and required consultation before surgery. These restrictions "have no demonstrated relationship to the problems of medical liability or liability insurance," Dr. Todd told the Subcommittee. "Rather the crises-need for remedies for these problems is being used as a device for imposition of further government meddling in the practice of medicine."

A somewhat surprised Sen. Kennedy has encountered a wall of opposition from the major groups involved in the medical liability crisis with respect to federal intervention as a solution. The Administration has joined the AMA, the American Hospital Association, and the American Trial Lawyers Association in urging that the federal government keep out of the liability picture at least for the time being.

Most of the suggested remedies so far carry bad news for some group, either increased governmental controls on physicians and hospitals, loss of fee income for lawyers, or some undermining of medical consumers' right to sue. In addition, insurance has always been very much a state prerogative in this country and federal legislation that infringes on states' powers over insurance is always difficult to enact.

In the absence of a clear and unequivocal call from some segment of the affected public and professions, the likelihood of Congressional action this year on a broad liability bill appears remote. An undercurrent of opinion on Capitol Hill seems to be that the problem should be faced when a national health insurance program is considered.

* * *

An Administration proposal to tie physician reimbursement for Medicare patients to levels related to but under "cost-of-living" indexes has drawn an angry protest from the AMA.

The new payment plan would carry out a provision of the Social Security Amendments law passed in 1972 which tied physicians' reimbursement under Medicare to economic factors geared to a cost-of-living index. HEW Department Secretary Caspar Wein-

berger said the proposed regulations were drafted "so that Medicare costs will follow rather than lead inflationary trends."

Richard E. Palmer, M.D., Chairman of the AMA Board of Trustees, charged that there is an "appalling lack of the most elementary and essential information" about the proposal, which he termed "another federal attempt to cop out on previous commitments to the elderly and to shift most of the burden onto the individual patient and the physician."

Thirty days were given by HEW for interested parties to comment on the proposed regulation published in the Federal Register on April 14.

"We have been given just 30 days to respond to a whole new set of HEW regulations to put a lid on Medicare reimbursement rates," Dr. Palmer said. "Since the proposed regulations relate to a law passed over two years ago, we think we are entitled to a minimum of 60 days to examine them and reply."

"Key parts of the regulations are not even available. HEW has offered examples of how the new regulations might apply. But we do not know where the data comes from nor how they were developed."

"These regulations apply to no other segment of the economy. They involve price rollbacks to 1971 levels. They also seem to be designed to save Medicare expenditures without regard to the possible impact on other segments of medical cost."

* * *

President Ford has nominated Theodore Cooper, M.D., as Assistant Secretary for Health at the HEW Department. The post is the most powerful health job in the federal government. Dr. Cooper succeeds Charles C. Edwards, M.D., who resigned January 5. A native of Trenton, N. J., Dr. Cooper, 46, has been serving as Acting Assistant Secretary. He is a physiologist, pharmacologist and surgeon. Dr. Cooper has served as Chief Deputy to Dr. Edwards following a stint as head of the National Heart and Lung Institute. He is regarded as a capable administrator whose close ties to the scientific-academic community will help him.

Ford also nominated Donald S. Frederickson, M.D., as Director of the National Institutes of Health. Dr. Frederickson, 50, replaces Robert S. Stone who resigned January 31. Dr. Frederickson also served as Director of the National Heart Institute and had been a member of the NIH scientific staff since 1953. He is an authority on fat transport in the circulation and on the disease of lipid metabolism.

* * *

A measure sponsored by the AMA to remove inequities and confusion over incentive pay bonuses for federal medical officers has been introduced in Congress. The bill would amend the law to enable all medical officers in the uniformed services to be eligible for the special pay bonus upon entering into active duty.

The incentive pay could be reduced or adjusted to reflect amounts that the federal government had already paid or any benefits which have already been

received by medical officers prior to the commencement of their active duty. Introduced by Rep. Thomas Downey (D-N. Y.), the bill applies to the military and the Public Health Service Commissioned Corps. There have been many complaints that the bonus provisions have led to instances where junior men were receiving higher pay than veteran superiors.

* * *

Congressional plans for quick action on health insurance for the unemployed have bogged down in a jurisdictional argument between the House Com-

merce and Ways and Means Committees. Both committees have bills—neither of which call for Social Security involvement—but rival committee members seem determined to block each others' bill from the floor.

The significance of the rivalry between the two bills has been expressed by Ways and Means member Representative James Hastings (R-N. Y.) who says the outcome "... will decide in this House who is going to write national health insurance legislation" for everybody.

Book Reviews

Post-Mortem. By David M. Spain, M.D., and Janet Kole. 296 pages. Price \$7.95. Garden City, N. Y.: Doubleday & Co., 1973.

This book is a collection of personal experiences in medico-legal investigation of widely publicized crimes, mostly related to the civil rights struggle of the past decade. The author is vividly demonstrating how the autopsy examination is contributing to the solution of medico-legal problems; his intense sense of righteous indignation, when confronted with cases of racial injustice, adds to the human aspects involved in the practice of forensic medicine.

A timely book, it should be read by anyone who is interested in the social and human side of forensic pathology.

MODESTO SCHARYJ, M.D.

Immunoassays for Drugs Subject to Abuse. By S. J. Mule, I. Sunshine, M. Braude, and R. E. Willette. 126 pages. Price, \$23.00. Cleveland, Ohio: CRC Press, 1974.

Licit and illicit use of drugs by an increasing proportion of a growing population has stimulated the search for suitable methods for identifying and detecting drugs in body fluids. The present volume consists of the proceedings of a one-day meeting combining two fields of growing interest, immunoassay and drug abuse. The meeting, held in March 1973, and sponsored by what is now called the National Institute on Drug Abuse, brought together a small group of outstanding scientists engaged in developing and evaluating immunoassay techniques for detecting drugs of abuse.

Under the heading immunoassays, current state of the art, general principles and methodologies are presented in six papers. In a second section four papers are presented on the critical evaluation and specific applications to detecting drugs of abuse. In addition,

the use of gas chromatography and mass spectrometry in confirming immunoassay results, especially positive ones, is the subject of another presentation. A summary of the discussions following the papers is provided at the end of each section.

This book offers an up-to-date reference for those interested in applying immunochemical techniques for drug detection. Such methods are relatively simple, rapid and adaptable to the assay of large numbers of samples. Although the drugs chosen as examples belong to the list of controlled drugs, the general basic information presented is applicable to other drugs as well. The material in the book is well presented and an adequate bibliography is given at the end of each paper. This volume is recommended to toxicologists, clinical chemists, clinicians and others as a good source of both general and specific information in the immunoassay of drugs.

NORMAN H. LEAKE, PH.D.

Current Therapy in Allergy. Edited by Claude A. Frazier, M.D. 302 pages. Price, \$15.00. Flushing N. Y.: Medical Examination Publishing Company, Inc., 1974.

This modest volume of 29 parts and 90 (!) contributors is promoted as an answer to "the question what to do now to relieve the patient of his allergic symptoms." Bearing in mind the title and expressed goal of this book, I must conclude sadly that for the most part it falls far short of its purpose. Though its title invites comparison to such notable works as *Current Pediatric Therapy* by Gellis and Kagan or Conn's *Current Therapy*, I am afraid this will serve only to reaffirm opinions of those critical of allergy as a specialty.

I feel Dr. Frazier's attempt to include several points of view on one subject has resulted in superficiality, redundancy and, ultimately, confusion for his reader.

Unfortunately, this applies even in controversial areas such as food hypersensitivity and chronic urticaria where multiple viewpoints might seem potentially helpful. Moreover, I must contend that the treatment offered frequently is not in keeping with the latest or best available clinical studies, and that attempts to relate therapy to pathophysiological mechanisms are woefully incomplete or inaccurate. Such important new drugs as metaproterenol and terbutaline are ignored and chromolyn sodium usually commented on only as an after-thought.

Indeed, I wonder whether it is even possible to write a purely therapeutic manual of allergy, since identification of specific etiologic factors (if they exist) and their consequent modification or elimination frequently is the "treatment." Practically, then, allergic diagnosis cannot be separated from treatment, yet diagnostically the book is also inadequate, not so much from what is said but rather from what has been omitted either due to lack of space or the aim to keep this volume "therapeutic."

Still, some sections are excellent such as those on dermatologic allergy; gastrointestinal allergy by Gerard, and Tamkin and Heiner; immunization reactions by Kamin; the allergic child in camp by Cushing and Radditz; and psychosomatic aspects of allergic dis-

ease by Aman Khan. Surprisingly, the section on otorheno-larngologic problems in allergy, long the stronghold of the anecdotal and testimonial "Rinkel technique" of allergy, is soundly and sensibly written except for the last contribution. Unfortunately, these sections would remain hidden from all but the most determined reader due to problems common to many editions with many contributors: great unevenness of the different sections and a poorly integrated, patchwork overall design. These are amenable to astute editing, something not in evidence in this little volume.

While I must agree with Dr. Frazier that a concise, practical guide to diagnosis and treatment of allergic problems for the "non-allergist" would be highly useful, I must say that this book does not fulfill that need. For the time being, the practitioner is probably best directed to *Allergic Diseases* edited by Roy Patterson.

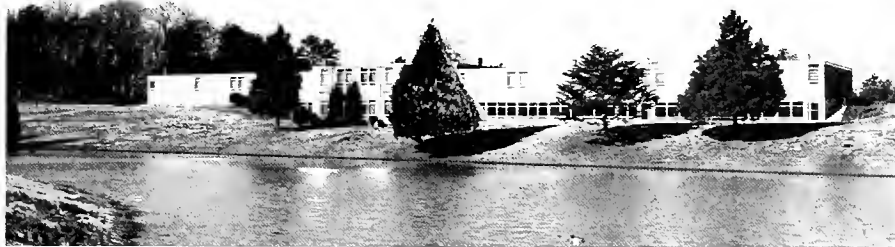
Incidentally, for those who still wish to acquire *Current Therapy of Allergy*, despite my reservations, I must point out an extremely serious typographical error on page 218 in which aqueous epinephrine 1:100 is recommended rather than its usual 1:1000 concentration. This could result in a ten-fold overdose if followed as written.

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In Memoriam

Hermann Martin Burian, M.D.

Dr. Hermann Martin Burian, Professor of Ophthalmology of the University of North Carolina School of Medicine, Clinical Professor of Ophthalmology of Duke University, and Professor Emeritus of Ophthalmology of the University of Iowa School of Medicine, died on November 25, 1974, in Milan, Italy. His death came while giving a series of distinguished guest lectureships.

Dr. Burian was born in Naples, Italy, January 14, 1906, the son of Dr. Richard Burian, a physiologist of distinction. He received his early education in Italy and later moved to Leipzig, Germany. When his father was appointed Professor of Physiology at the University of Belgrade, the family moved to Yugoslavia and there Dr. Burian received his medical degree in 1930.

Following medical school, Dr. Burian pursued his postgraduate studies with some of the most prominent European ophthalmologists of the day. He worked with Professor Weigert at Leipzig on the photochemistry of vision. He served his ophthalmology training under Dr. Siegrist and Dr. Goldmann at the University Eye Clinic, Berne, Switzerland, and later studied under Nizetic at Belgrade and physiological optics with Tschermak at Prague.

In 1936 he came to the United States to work at the Dartmouth Eye Institute with Professor Alfred Bielschowsky and later with Dr. Walter B. Lancaster. Dr. Burian served as chief of the Eye Institute from 1942 to 1945. With the closing of the Dartmouth Eye Institute he entered private practice in Boston. In 1951 he accepted a position as Professor of Ophthalmology at the University of Iowa Medical School. During his years at Dartmouth and Iowa he made many important

contributions to ophthalmology in the field of ocular motility, which was his first love, and in other areas as well. In 1971 he came to the University of North Carolina as Professor of Ophthalmology and to Duke University as Clinical Professor of Ophthalmology.

Dr. Hermann Burian's name stands prominent among twentieth-century ophthalmologists. He represented the highest in academic and scientific achievement. He is recognized for his outstanding contributions in many areas of ophthalmology, particularly in the field of strabismus. His enormous capacity for work led to the publication of over 200 papers, and culminated with the publication "Binocular Vision and Ocular Motility" written in association with Von Noorden in 1974. Dr. Burian held many offices of both functional and honorary nature. He was the recipient of numerous medals, including the Hektoen Medal, the Proctor Medal, and the Cavarra Medal, and delivered many memorial lectures, including the Scobee and Gifford lectures. His interests outside the fields of medicine were extensive, and in the areas of linguistics, music, art and archaeology, he was a true scholar.

Dr. Hermann Burian was a warm, gracious and charming individual and inspiring teacher. The universities which he served, the residents whom he taught, and those who knew him as a personal friend, will not forget the profound influence this remarkable man had on them and the specialty of ophthalmology.

Dr. Burian is survived by his wife, Gladys Simmons Burian, and two sons, Richard and Peter.

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July 1975, Vol. 36, No. 7

NORTH CAROLINA

Medical Journal

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orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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INDICATIONS: 1 **Endocrine Disorders:** Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice, synthetic analogs may be used in conjunction with mineralocorticoids where applicable, in infancy, mineralocorticoid supplementation is of particular importance). Congenital adrenal hyperplasia, nonsuppurative thyroiditis, hypercalcemia associated with cancer. 2 **Rheumatic Disorders:** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in psoriatic arthritis, rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis; acute and subacute bursitis, acute nonspecific tenosynovitis, acute gouty arthritis. 3 **Collagen Diseases:** During an exacerbation or as maintenance therapy in selected cases of—Systemic lupus erythematosus, acute rheumatic carditis. 4 **Dermatologic Diseases:** Pemphigus, bullous dermatitis herpetiformis, severe erythema multiforme (Stevens-Johnson syndrome), exfoliative dermatitis, mycosis fungoides, severe psoriasis. 5 **Allergic States:** Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment. Seasonal or perennial allergic rhinitis, bronchial asthma, contact dermatitis, atopic dermatitis, serum sickness. 6 **Ophthalmic Diseases:** Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as—allergic corneal marginal ulcers, herpes zoster ophthalmicus, anterior segment inflammation, diffuse posterior uveitis and choroiditis, sympathetic ophthalmia, allergic conjunctivitis, keratitis, choroiditis, optic neuritis, iritis and iridocyclitis. 7 **Respiratory Diseases:** Symptomatic sarcoidosis, Loeffler's syndrome not manageable by other means, berylliosis; fulminating or disseminated pulmonary tuberculosis when concurrently accompanied by appropriate antituberculous chemotherapy. 8 **Hematologic Disorders:** Idiopathic and secondary thrombocytopenia in adults, acquired (autoimmune) hemolytic anemia, erythroblastopenia (RBC anemia), congenital (erythroid) hyperplastic anemia. 9 **Neoplastic Diseases:** For palliative management of leukemias and lymphomas in adults, acute leukemia of childhood. 10 **Edematous States:** To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus. 11. **Miscellaneous:** Tuberculous meningitis with subarachnoid block or impending block when concurrently accompanied by appropriate antituberculous chemotherapy. Systemic dermatomyositis (polymyositis).

CONTRAINDICATIONS: Systemic fungal infections.

WARNINGS: In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection and new infections may appear during their use. There may also be decreased resistance and inability to localize infection. Prolonged use may enhance the establishment of secondary ocular infections due to fungi or viruses.

Since adequate human reproductive studies have not been done, the use in pregnancy, nursing mothers or women of childbearing potential requires that the possible benefits be weighed against the potential hazards to the mother and the embryo or fetus. Infants should be observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy, patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

PRECAUTIONS: Hormone therapy is an adjunct to, and not a replacement for, conventional therapy.

Dosage should be individualized according to the severity of the disease and the response of the patient. As soon as a satisfactory clinical response is obtained, the daily dose should be reduced, either to termination of treatment or to the minimal effective maintenance dose level. The lowest possible dose should be used and when reduction in dosage is possible, the reduction should be gradual if the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued.

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy, therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism; and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Psychic derangements may appear or existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia.

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection, diverticulitis, fresh intestinal anastomoses, active or latent peptic ulcer, renal insufficiency, hypertension, osteoporosis, and myasthenia gravis.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed.

Blood pressure, body weight, routine laboratory studies, including 2-hour postprandial blood glucose and serum potassium, and a chest X-ray should be obtained at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with known or suspected peptic ulcer disease.

ADVERSE REACTIONS: Fluid and Electrolyte Disturbances. Sodium retention, fluid retention, congestive heart failure in susceptible patients, potassium loss, hypokalemic alkalosis, hypertension. **Musculoskeletal.** Muscle weakness, steroid myopathy, loss of muscle mass, osteoporosis, vertebral compression fractures, aseptic necrosis of femoral and humeral heads, pathologic fracture of long bones. **Gastrointestinal.** Peptic ulcer with possible perforation and hemorrhage, pancreatitis, abdominal distention, ulcerative esophagitis. **Dermatologic.** Impaired wound healing, thin fragile skin, petechiae and ecchymoses, facial erythema, increased sweating. May suppress reactions to skin tests. **Neurological.** Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment. Convulsions; vertigo, headache. **Endocrine.** Development of Cushingoid state, suppression of growth in children, secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness, menstrual irregularities, decreased carbohydrate tolerance, manifestations of latent diabetes mellitus, increased requirements for insulin or oral hypoglycemic agents in diabetics. **Ophthalmic.** Posterior subcapsular cataracts, increased intraocular pressure, glaucoma, exophthalmos. **Metabolic.** Negative nitrogen balance due to protein catabolism.

DOSAGE AND ADMINISTRATION: The initial dosage may vary from 4 to 48 mg per day. Requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient. The proper maintenance dosage should be determined by decreasing the initial dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

ALTERNATE-DAY THERAPY (ADT): ADT is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects including pituitary-adrenal suppression, the Cushingoid state, corticoid withdrawal symptoms, and growth suppression in children.

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Message of the President to the House of Delegates

Frank R. Reynolds, M.D.

IT is customary at this time for the retiring President to give his state of the union address to the House of Delegates. This year in particular I think that it will be necessary to interrelate the activities of our state society more closely with those of our peer organization, the AMA.

First I would like to point out to you, if you were not already aware, what a strong organization our state society is. Our forefathers and our predecessors have formulated through the constitution and bylaws and committee structure a society that can remain active and viable through almost any kind of situation. We have built up such an efficient headquarters staff that they can survive any administration—even mine. I was truly amazed at how little I thought I knew one year ago and how much I think I know now about this society. In the interval, the ship of state has sailed smoothly on.

I was not dry behind the ears and my ulcer had hardly stopped bleeding when our first problem reared its ugly head—a request by St. Paul Fire and Marine Insurance Company for an 82.3% rate increase in professional liability insurance for the physicians of North Carolina. I appeared before Insurance Commissioner John Ingram on your behalf during last summer. However, he did not make a final decision until December with St. Paul announcing that it was pulling out of North Carolina January 1, 1975, if no increase was granted. As you are no doubt aware, Commissioner Ingram granted a temporary 82.3% rate increase until July 1, 1975. In the meantime, St. Paul has announced that it is retiring from the “occurrence” type policy and will issue only a “claims made” type policy after July 1, 1975. This problem certainly has the potential of being one of the biggest

headaches that the society will face in the future year.

I will attempt to explain briefly some of the terminology and some of the problems as I see them. First, an occurrence type policy is a type that you are all familiar with. It is one that covers any act by you that occurred during the life of the policy no matter when the claim was or is filed. A claims made type policy covers only those claims that are made during the year that the policy is in force. One can readily see the deficiencies in the latter type policy if the physician decides to change companies or decides to retire or change locations. At that time he would have to buy a “discovery” type policy to cover all his past actions under the claims made type policy. At the present time, there has been no final decision from Commissioner Ingram on this concerning his approval of the claims made type policy. If it is not approved, then St. Paul will discontinue writing professional liability insurance in North Carolina, unless they are forced to do so by the passage of Commissioner Ingram’s proposal creating a liability insurance pool of companies writing any type of liability insurance in the state other than automobile liability. A bill to this effect was introduced by Dr. John Gamble.

In addition to the above problems concerning the availability of liability insurance, there is the other problem of creating a climate in North Carolina that will encourage insurance companies to offer liability coverage in our state. A special ad hoc committee on professional liability insurance has been appointed, headed by Dr. Ira Hardy of Greenville, to investigate the many causes of progressively increasing liability insurance rates and to advise the executive council which causes it feels are primarily responsible for our increase in rates here in North Carolina. The AMA has studied this problem extensively and has held several meetings with the high officials of the companies that write professional liability insurance in this country.

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Reprint requests to Dr. Reynolds, 1613 Dock Street, Wilmington, North Carolina 28401.

Their advice is that the problem must be handled on a state by state basis. The problems and solutions that will benefit California, New York or New Jersey will not necessarily be the problems or solutions for us here in North Carolina. Some of the suggested solutions are these: (1) Create a binding arbitration panel; (2) reduce the statute of limitations; (3) remove the ad damnum clause specifying dollar amounts; (4) clarify the doctrine of informed consent; (5) define medical malpractice more specifically; (6) have a scale of sliding contingency fees and (7) have a workman's compensation type award.

When the right solutions for us here in North Carolina are identified, they will be drawn into a bill which will be presented to the legislature. A solution to this crisis must be forthcoming both for relief of physicians and patients, because, after all, the increased cost of practicing "defensive medicine" and the increasing premiums will ultimately be passed on to the patient.

Rep. John Gamble has introduced another bill, H.B. 567, to create a study commission to investigate the professional liability insurance problem and report to the legislature next year. This report shall contain all findings, conclusions and recommendations for legislation concerning (1) the problems which insurance companies face in writing professional liability insurance in North Carolina; (2) problems which professionals face in obtaining professional liability insurance in North Carolina and (3) the reason for, and any possible remedies for, the increased cost of obtaining professional liability insurance in North Carolina. This bill will certainly help to clarify the situation; however, there is some question whether some of the problems need to be identified and action taken before another year has passed.

Headquarters Staff Enlargement

Our headquarters staff has been enlarged and streamlined by Mr. Hilliard to keep up with the increased work load in these trying times. Mr. John Evenson and Mr. Mike Cates have been employed as field representatives. These new men will enable the medical society to improve its relationship with county societies, committees and individual members. Mr. Steve Morrisette has been delegated to full time legislative liaison work. With the increasing number of health related bills in the legislature, this has been a fulltime job. Mr. Gene Sauls has been designated director of field service. Mrs. LaRue King is assistant to the executive director and convention coordinator. It has certainly appeared to me that we have an excellent, efficient, dedicated headquarters staff constantly working to meet our medical society objectives. I will now try to highlight the work of a few of our more active committees.

Medical Education Committee

As most of you will recall, the House of Delegates last year voted to require 150 hours of continuing medical education every three years reported annu-

ally as a requirement for membership in the state society. Your committee on medical education has met and is preparing a form to be mailed shortly. It is also planning to apply to the AMA Council on Medical Education to be the accrediting agency for our state.

The primary focus of continuing medical education accreditation at the local level will be upon (1) local hospitals which have continuing medical education activities limited to hospital staffs and physicians in the local community; (2) medical organizations which do not have national scope, e.g., county or other local societies, and (3) other organizations or institutions which sponsor or promote continuing education for physicians essentially local in nature, appropriate to the needs of the profession. Your committee feels that this service is greatly needed in the state and can be best applied by this committee.

Committee on Medical Aspects of Sports

This committee, as usual, has been one of the most active committees of the society. It held its annual sports medicine symposium at the Blockade Runner at Wrightsville Beach over the weekend of July 4 and it was well attended with excellent speakers. This year's symposium was scheduled the weekend of July 3-5 at Appalachian State University's Center for Continuing Education in Boone.

This committee has continued to successfully fight the chiropractic association in its request to perform free athletic physical examinations on high school athletes. You will note that these forms must be signed by a "physician licensed to practice medicine in North Carolina." I feel certain this committee will continue its outstanding service to the society and to the athletes of our state. Due largely to the efforts of this committee, North Carolina has one of the outstanding sports medicine divisions of the Department of Public Instruction in the entire country and many states have copied this concept.

Blue Shield Committee

This committee continues to perform an outstanding service to the doctors of our state. A review committee meets every month to adjudicate claims and review educational literature. It has been recommended by the committee and the commissioner, and approved by the executive council, that the president shall appoint the members of the committee and that the terms of office shall be one year, subject to reappointment annually for no more than four additional terms, contiguous or not. The president shall appoint at least one member from each specialty and as many more as are necessary for the proper functioning of the committee. He shall consult with the specialty sections regarding the choices that he makes and he shall endeavor to insure as wide a geographic and specialty representation as possible.

This change will enable the committee to perform its duties more efficiently and will give members time to gain experience in this important field of claims adjudication. The committee has also recommended that

Blue Cross employ a medical director, and the management is in the process of doing just this.

I feel that one group of unsung elected, dedicated members of our society has been the eight physicians who serve as our representatives on the North Carolina Blue Cross and Blue Shield Board of Trustees. These physicians spend one day a month in Durham representing us in policy matters for the corporation. They are extremely knowledgeable in these matters and represent our interests very well. It is certainly a shame that our membership on this board will be cut from eight to six physicians next year, since the wave of consumerism has swept two more consumers on as members of the board. Our representation will be cut from eight to six and the hospital association will also be cut from eight to six members with thirteen members representing the public. The entire board works well together and they have a very well run, efficient organization.

Insurance Industry Committee

This committee does the claims adjudication for the other two-thirds of the private insurance industry in our state. Under Dr. Charles Duckett it has done an excellent, efficient job. It works well with the Health Insurance Council, incidentally, whose name has now been changed to the North Carolina Council on Consumer and Professional Relations. This group of approximately 25 hardworking physicians certainly deserve a great deal of thanks from the other members of our society.

Relative Value Study Committee

Your committee on relative value study has met and accumulated what it thought was all the data necessary for publication of a new revised relative value study. However, some questions were raised by several specialty organizations as to the relativity of the values that were assigned when they were compared with various specialty procedures within a section of the book. Consequently, the publication is being delayed until these discrepancies can be ironed out. It is hoped that it will be in the hands of the printer by this summer.

Mental Health Committee

This committee under the able leadership of Dr. Phil Nelson continues to be one of the most active committees we have. They co-sponsored a banquet and cocktail party for the legislators during Alcoholism Awareness Week which was very well attended. They continue to have a very close, healthy working relationship with the State Division of Mental Health Services and its director, Dr. Mike Zarzar. They are also constantly working to upgrade the quality of care obtainable in the various mental health centers around the state.

Traffic Safety Committee

This committee under the chairmanship of the "ole workhorse," Ed Beddingfield, continues to be very

active. It is preparing to push for a law requiring mandatory seat belt usage and has requested Governor Holshouser and Col. E. W. Jones, Commander of the Highway Patrol, to see that the patrol's report of highway deaths includes the number of victims who were or were not using seat belts at the time of the accident. They also recommended to the executive council that it support legislation creating a classified driver's licensing system in North Carolina. They also have requested that the Division of Motor Vehicles take the proper administrative steps to see that reports for driving under the influence distinguish between whether it is driving under the influence of drugs or driving under the influence of alcohol.

Auxiliary

Cooperation and support by the auxiliary have been excellent. It continues to set records each year in the amount of contributions to the AMA-ERF Fund which it is so well able to promote. We cooperated with the auxiliary in having a joint meeting with their representatives and representatives from Dr. Craig Phillips' Department of Public Instruction concerning health education in our public schools. This meeting came about following an article by Mrs. Martha Martinat in the October issue of the NORTH CAROLINA MEDICAL JOURNAL entitled "Survey of Health Education in North Carolina Public Schools." Mrs. Martinat is chairman of the health education committee of the auxiliary. Dr. Phillips has asked that three members from the medical society and three members from the auxiliary form an advisory committee to his department concerning health education in the public schools. I feel that this is a beginning of an excellent relationship and a great deal of good will emerge from this joint committee.

The auxiliary president, Mrs. Lu Russell, has been a tireless worker and expended great energy in making her term a big success.

The good will this group generates for the medical profession could not be obtained by any method. We wish them continued success under their new president, Mrs. Shirley Herring.

North Carolina Medical Society membership is at a new high. At the close of 1974, we had almost 4,500 members and expect to exceed that number this year. However, North Carolina members of the AMA have dropped alarmingly since this time last year. Since we have represented here today in this room leaders and future leaders of medicine in North Carolina, I can say to you that something should be done to correct this.

The AMA is the most prestigious medical organization in the world. It is the only one that can speak for almost 200,000 doctors. Membership includes physicians of all specialties, educators, researchers, administrators, interns, residents and students. Every form of practice is represented—solo, group and partnership. Together 200,000 individual physicians represent medicine united.

Of course, all of these do not share the same views. There are conservatives, liberals and middle-of-the-

readers and obviously there must be differences of opinion—but above all that, the AMA is the only thing that can bind us all together. Purely and simply, medicine needs a strong organization now more than ever before.

Most of the AMA members want to hear about action. The AMA on your behalf has researched, prepared and testified an average of 50 times per year before congressional committees and other similar groups. This does not include mixed opinions submitted to the proper bodies in every case of health legislation.

I am sure you are aware of the AMA suit against the federal government to have final Medicare and Medicaid utilization review regulations declared illegal and their implementation permanently halted. I might add that according to an AMA official legislation is being studied and planned against "maximum allowable cost," and against P. L. 93-641—National Health Planning and Resources Development Act of 1974 which is, without a doubt, the upcoming nemesis of medicine.

Of particular importance right now is the AMA-led struggle of professional liability insurance, a critical problem throughout the United States as well as in North Carolina. Physicians now seem to want action and visibility. They want their professional organization to become more aggressive. They are getting it. All of this action costs money. The AMA has the same problem with inflation and increase in cost that everyone else has. Increasing programs and increasing involvement also increase expenditures. The AMA was losing approximately \$1 million a month the latter part of 1974. The House of Delegates voted an assessment of \$60 per member starting January 1 and only a little more than 60% of the membership has paid this. In addition, the membership is down rather than up. I say to you today that all of you should go back to

your county societies, stand up and put in a plug for the AMA.

Simply and bluntly, the fight is now more critical than ever. At stake, at least in my mind, is the most important thing of all, survival of the medical profession as we know it. The government should not be allowed to dictate the trends of medical practice and medical education. Where would we be now without the AMA? Where would medicine be? The AMA dues are a small price to pay for our survival.

There is not time enough to mention all the many accomplishments of your other committees. The legislative committee has been unusually busy with the legislature in session since January. The public relations committee under Dr. John McCain's direction put on an excellent leadership conference at the headquarters building in February. It was well attended with an excellent program and many favorable comments were received from the membership.

It has certainly been a privilege and a pleasure to work with the over 650 members of our society in its committees. The commissioners have been extremely conscientious and capable in handling the committees under their jurisdiction. The executive council has been long suffering and patient with putting up with me throughout this year. The headquarters staff and personnel have been simply wonderful and without their continued help the year certainly would not have run so smoothly. To all of you, I am most appreciative for your help and cooperation. I can say to you that the North Carolina Medical Society symbolizes excellence in professionalism and is held in the highest respect throughout the state. Our forefathers and predecessors have given us this heritage. I only hope that I have helped to maintain this heritage with your help and God's help. It has been a privilege in every way to have had the honor of serving as your president throughout this past year.

Not only in this farm-house kitchen, but wherever one might place him, he instinctively took command, while from his great knowledge of human nature he could understand and help many of his patients whose ailments were not wholly physical. He seemed to read at a glance the shame and sorrow of the young woman who had fled to the home of her childhood, dying and worse than defeated, from the battle-field of life. And in this first moment he recognized with dismay the effects of that passion for strong drink which had been the curse of more than one of her ancestors. Even the pallor and the purifying influence of her mortal illness could not disguise these unmistakable signs.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 33-34.

The President's Farewell Address

Frank R. Reynolds, M.D.

MEMBERS of the North Carolina Medical Society, guests and friends: One year ago you placed your confidence in me to serve as your president for the past year. It was indeed an honor and a responsibility which I have kept constantly before me. In my travels around the state, I have tried to represent you well and have been happily impressed by the high esteem that our society engenders with the public.

Daddy Ross has stated previously the purpose of a final address by the president of the society is to account for his stewardship and to transmit any information or ideas concerning the functioning of the organization that he might have acquired during the past year.

One year ago we were in the middle of a big debate concerning PSRO, whether it was constitutional and how to make it work in North Carolina. One year later, I can report to you that it is progressing with much less furor than we all predicted. A large part of this success must be credited to the North Carolina Medical Peer Review Foundation and its President, Dr. Frank Sohmer. There are eight PSRO areas in North Carolina and all of these either have conditional professional standard review organizations or they are in the process of forming one. The state foundation received an educational grant from the regional medical program and a federal grant to act as the PSRO Support Center. At present they are in the process of negotiating a contract to do the professional review for the state Medicaid program. They also have contracted with the Division of Social Services to do the

hospital admissions review program (HARP). This has been an extremely active year for the PSRO program in North Carolina and certainly this time last year no one would have believed that this much progress could have been accomplished in one year. So far the cooperation by the medical profession in this state has been excellent. One only wonders if this will continue as the action gets hotter.

National Health Planning and Resources Development Act of 1974

While the medical profession had its attention directed to HR 1 of P.L. 92-603 of 1972 (or the PSRO law), Congress passed, in November 1974 P.L. 93-641, an act known as the National Health Planning and Resources Development Act of 1974. The AMA and your North Carolina delegation strongly opposed this law, but as usual it was passed over our objections. In my opinion, this act will make the PSRO/Act read like a Boy Scout handbook. This new law represents the biggest and darkest storm cloud that the profession of medicine has recently faced. It is descending on us now and, quite honestly, its impact on the medical profession cannot be fully determined. It is one of the most comprehensive, bureaucratic acts to ever come out of Congress in the health care field.

If I sound alarmed, I am. If this presentation sounds alarming, I want it to be. And if you are alarmed, believe me, you have good reason to be. If you are not alarmed, you should be.

Purely and simply, P.L. 93-641 amounts to federalization of health care. It is a direct attempt by the federal government to dictate health care in the United States. The law will dictate and dominate medicine all the way from medical education to private practice and includes the control of medical costs in the con-

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Reprint requests to Dr. Reynolds, 1613 Dock Street, Wilmington, North Carolina 28401

struction of new or enlarged hospital facilities which was previously covered under the old Hill-Burton Act.

In effect this law makes medicine a public utility. It will, with very few exceptions, put control of health care in America in the hands of the Secretary of Health, Education and Welfare and will empower him with sweeping jurisdiction of all the areas covered in the law—including your office.

Let me briefly try to break down this very complicated law so we can see what lies ahead of us. The law is virtually without specific definition so it is impossible at this time to cover all the possible implications.

P. L. 93-641, according to the bill, is designed to improve health care on the local level through the establishment of Health System Agencies (HSA). The HSAs are the bottom of a tier system. At the top is the secretary of HEW who is empowered to issue national guidelines for health policies. These guidelines would include standards for the "appropriate supply, distribution and organization of health resources." The law requires the secretary to set national goals for health care which would serve as guidelines for all other agencies at all other levels including HSAs.

The law would establish a National Council on Health Planning and Development which, like agencies called for at all levels from federal to state to local, would be dominated by consumers and not by providers of health care. The national council would be responsible to the HEW secretary to advise, consult and recommend national guidelines, their implementation and administration. But the ultimate decision rests with the secretary. Then as we descend this complicated tier, state agencies would be contracted with by the secretary only after his approval according to his own national guidelines. State agencies acting for the secretary would in turn have to have an administrative program approved by the secretary and would have to establish a statewide coordinating health council—again consumer dominated.

The statewide council would review the state health plans and budget but could be overruled by the secretary. In short, everything done on a state level including personnel, methods of administration, standards of evaluation of performance and projects review standards would have to be approved by the secretary according to his guidelines. Now, finally, we come to the local HSAs which would be established once health service areas are designated. North Carolina looks as if there will be six such areas. If the secretary does not approve of these areas, he has the power to overrule the governor's selection. Once the areas are designated, the HSAs would be responsible for establishing, reviewing and implementing health plans according to the secretary's guidelines. The HSAs by law must consist of a majority of consumers with about 1/3 of the HSA council coming from health areas but not necessarily private medicine.

I think that is about as far as we need to go with the organizational concept of the law. What is apparent and very alarming is that medicine will be regulated

and told what route to take. An additional factor very alarming to North Carolina especially is that grants for medical schools would be controlled by the secretary of HEW.

Sweeping powers of the HEW secretary must be brought to light. To begin with the secretary is empowered to set the goals and guidelines we will have to live by. His power to enter one year contracts (including review of all HSA health plans and HSA budgets) obviously would make the local HSAs more aware of the secretary's priorities than the local priorities, which is the basic premise of the law. The secretary is also empowered to provide grants and establish all criteria the states must meet as well as establishing minimum review criteria and develop agencies pursuant to his regulations. Further, the secretary is empowered to establish within one year a uniform system of calculating cost—a uniform system across the country, a uniform system for calculating rates, and a classification system of health services according to costs and rates which could reach right into the physician's office. This is the first federal law pertaining to health care in which I have seen the wording "state rate regulations."

Finally the secretary is empowered to review the structure, function, performance, plans, personnel and accomplishments of the entire system every three years. This gives him complete control of health care in America. In short, the potential of this bill is overwhelming. I frankly see nothing that is helpful or even encouraging toward the improvement and quality of medicine practiced in this state or in the nation. As I said at the start, the law is alarming and very discouraging. It is a battle we cannot lose, and it fortifies what I said to the House of Delegates Thursday about AMA membership. Now more than ever before, we need unity.

MEDPAC and Legislation

As you can see from my previous remarks, it is imperative that we get the true picture of the private practice of medicine across to our legislators. They need to be able to identify and understand our problems. You can see the value of MEDPAC membership to our organization. You can encourage educational and informational programs for the public first and then offer financial assistance to those who are sympathetic to our views. Never before have we had a greater need for friends in the legislature, both on a state and national level.

Our membership has continued to increase and the end of 1974 saw us at an all time high of over 4,200 members.

AMA

The AMA membership was also at an all time high in December but has dropped alarmingly since the first of the year. It behooves us all to put in a plug for AMA membership. There is no hope to combat the rising tide of federalization of medicine unless we stay united and pull together. Just because you disagree

with one issue, that is no reason to withdraw your financial support from the many fine scientific and educational aspects of the federation. Stop for a minute and ask yourself, where would we be today without the AMA? Who would fight the battles of the future on the 3,000 or so health related bills before Congress or relations with other health professions? Will labor unions of doctors preserve us? Hardly! What are the membership dues in these unions? Could specialty societies supplant the AMA? Hardly! They are necessary for the specialties but they certainly could not speak for all of organized medicine. Let's face it—you and I need the AMA and you and I had better work for the AMA. You can see the high caliber of leadership when you hear Dr. Malcolm Todd's address tomorrow.

Continuing Medical Education

Your 1973 House of Delegates passed a resolution which requires 150 hours of continuing medical education every three years reportable annually. Your committee on medical education is planning to apply to the AMA Council on Medical Education to be the accrediting agency for our state. It will greatly facilitate the ease with which a program or course can receive accreditation. I predict that it will be extremely easy for a physician to obtain his education requirements within easy traveling distance from his office.

Several Area Health Education Centers (AHEC) will be in operation shortly and all of their programs will be automatically approved through their university affiliation. This will bring medical center teaching right down to the local level. We are indeed fortunate that the legislature was foresighted enough to finance and implement this outstanding program.

National Health Insurance

The issue of national health insurance has been one of the most controversial ones before Congress. The only good thing that can be said about the recent recession is that it has postponed national health insurance. It was agreed among the legislators that our great country was just not financially able to absorb the added costs that were estimated for national health insurance. We represent the only industrialized country in the world that doesn't have some form of national health insurance.

The AMA is seeking to find a livable, workable solution for providing health insurance to our nation's citizens within a price that can be afforded by our nation that will avoid governmental intervention and bureaucracy of administration and will avoid the financing through a payroll tax. In pursuit of this philosophy, they have developed guidelines in a general format with which some agreement and consensus has been reached with other elements of the voluntary sector of the health profession and from this they hope to again have an entry in the Congressional race for national health insurance.

These guidelines include (1) a minimum of federal

involvement in administration of any national health insurance programs; (2) state jurisdiction with respect to the licensure and certification of profession health personnel and regulation of insurance; (3) minimum federal dollars in financing programs for comprehensive coverage at least possible cost; (4) funding through federal, state and private funds including (a) employer-employee contributions for private health insurance and (b) an individual tax credit is applied for full health care protection; (5) no added Social Security tax financing; (6) no administration by Social Security; (7) cost sharing by participating individuals and families and a subsidy for the indigent scale according to income; (8) use of private insurance on a risk and underwriting basis; (9) comprehensive coverage, basic and catastrophic for the entire population; (10) pluralism in methods of health care delivery; (11) cost and quality controls as appropriate; (12) continuity and coordination of benefits and (13) a separation of medical and institutional components in financing so as to provide that separate expenditures are ascertainable.

Now you can see that we have a big order, but if you think them all through, that is what free enterprise medicine is all about. Fortunately the controversy has been over the method of financing and not trying to create a national health service such as the British system. If it must come about, we certainly want to see that the doctor-patient relationship is left undisturbed.

Conclusion

I covered the medical liability insurance problem in detail Thursday in my address to the House of Delegates. Suffice it to say that the society is working hard to improve the availability and the atmosphere in the state for the insurance companies. If no other policy is available, we can live with the "claims made" type policy while we seek to bring down the loss experience in our state.

I have covered only a few of the issues with which we have been engaged and which will occupy the incoming president's time. We are indeed fortunate in having a man as experienced, dedicated and capable as Dr. James Davis to lead us in the coming year. I wish him Godspeed and the best of luck.

I wish to thank again Mr. William Hilliard and his efficient headquarters staff for their invaluable aid throughout the year. The smooth continuity of our many committees and policies could not be possible without their help.

I must mention here that my work this past year would not have been possible without the help and cooperation of my fellow pediatricians in Wilmington—particularly Dr. George Koseruba. It was through their extra work that I have been able to spend the necessary time in Raleigh and around the state. To them I will be eternally grateful. To my fellow officers, commissioners and committee chairmen, I can only say thank you for a job well done. It has been a privilege and an honor to have served as your president for the past year.

Ainhum (Dactylolysis Spontanea): Report of a Case

Larry Stephenson, M.D.*

ALTHOUGH Messum¹ is generally credited with first describing ainhum in 1821, it was more completely described by da Silva Lima² in 1867 when the name of the disease appeared for the first time (ainhum meaning "to saw," from the Yoruba dialect).³ In the United States, the first reported case was apparently that of Hornaday in 1881⁴; since then, approximately 122 cases have been reported in this country.^{1-3, 5-9} My experience with the disease is described in this report.

CASE REPORT

A 26-year-old black man was hospitalized because of severe pain in his right fifth toe. Physical examination showed a constricting band at the base of the fifth right toe (Figure 1), which he had first noticed a few years previously. As the condition progressed, the pain worsened and he was unable to work. The medical and family histories were unremarkable. Laboratory studies, including tests for syphilis and sickle cell screening, were normal. Roentgenological examination of the right foot showed bone resorption at the level of the constriction. The toe was am-



Figure 1

putated with a racquet-type incision being employed. The patient's postoperative course was uneventful and he returned to work after three weeks.

DISCUSSION

Ainhum is manifested by a deep soft tissue groove, similar to a hyperkeratotic band in the epidermis and by fibrosis in the dermis beneath the groove with the connective tissue oriented longitudinally. The groove begins medially at the fifth toe and progresses circumferentially; as it deepens, the blood supply is compromised and eventually a spontaneous amputation may occur. Radiographically, bone density appears decreased at the level of the band with thinning of the cortex and resorption distally.

The disease is seen most frequently in the male, usually, if not exclusively in the Negro and is most common along the west coast of Africa. It has been reported in a patient six years of age but most commonly occurs during the third to fifth decades of life. It is bilateral in seventy-five percent of patients but parallel development is not necessarily observed in each fifth toe. Browne² found involvement restricted to the fifth toes in one hundred patients seen during twenty-eight years in Nigeria with the constriction usually affecting the proximal phalanx. He suggested that chronic fissuring in hyperkeratotic skin preceded the constriction and agreed with others^{9, 11-14} who proposed a propensity of blacks to respond to chronic or recurring injury by overproduction of fibrous tissue at the site of injury. Chronic infection has also been offered as an explanation for the lesion but seems extremely unlikely because the immunity of the other toes would require a special vulnerability of the little toes. Cole¹⁰ further found no evidence of infection or inflammation in fifty-four subjects and postulated changes of unknown origin in the basal layer of the epidermis.

As ainhum progresses and pain becomes a prominent symptom,

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Request for reprints to Dr. Stephenson, Department of Surgery, University Hospital, Birmingham, Alabama 35294.

surgery may be required. Seventy-eight percent of Cole's patients had severe pain and nine were operated upon with resection of the constricting band and Z-plasty¹⁰; all had immediate relief and the disease did not recur during an eighteen month follow-up. In more advanced cases, amputation may be necessary.

SUMMARY

Ainhum is an acquired disease of unknown cause which occurs predominantly in the black and is characterized by spontaneous fib-

rous constriction of the fifth toe at its base. When seen in early stages, resection of the constricting band and Z-plasty may be successful but as the process advances and the pain becomes severe, amputation may be necessary.

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"... for intense, self-centered, smouldering volcanoes of humanity, New England cannot be matched the world over. It's like the regions in Iceland that are full of geysers. I don't know whether it is the inheritance from those people who broke away from the old countries, and who ought to be matched to tremendous circumstances of life, but now and then there comes an amazingly explosive and uncontrollable temperament that goes all to pieces from its own conservation and accumulation of force. By and by you will have all blown up, you quiet descendants of the Pilgrims and Puritans, and have let off your superfluous wickedness like blizzards; and when the blizzards of each family have spent themselves you will grow dull and sober, and all on a level, and be free from the troubles of a transition state. Now, you're neither a new country nor an old one. You ought to see something of the older civilizations to understand what peace of mind is. Unless some importation of explosive material from the westward stirs them up, one century is made the pattern for the next. But it is perfectly wonderful what this climate does for people who come to it, — a south of Ireland fellow, for instance, who has let himself be rained on and then waited for the sun to dry him again, and has grubbed a little in a bit of ground, just enough to hint to it that it had better be making a crop of potatoes for him."—*A Country Doctor*, Sarah Orne Jewett, 1884, p 100.

Editorials

COUNTRY DOCTOR II

Since we in this state are trying to establish a contemporary version of the country doctor, it behooves us to examine the sources of the myths surrounding the original version. For this purpose we will be publishing for some time excerpts from *A Country Doctor*, a novel of medicine in Maine, published in 1884. Its author, Sarah Orne Jewett, was the daughter of a Maine practitioner and rode with him in an often cold buggy on his rural rounds, stoking her desire to study medicine. In a way we can be thankful that she turned to literature instead. Otherwise we would not have a fine collection of short stories and novels written by an observer more astute than most of us. *A Country Doctor* deals with the relationship between Dr. Leslie and his ward, Nan, particularly as Nan struggles to reconcile her desire to become a doctor with the things expected of women in those days. Miss Jewett speaks clearly across ninety years.

While considering medical education and country doctors, it may come as a shock to recall that many of those country doctors had to struggle mightily to achieve their rudiments. Distances were longer and money scarcer, particularly in a South left destitute by the Civil War. The state of the art was more art than science. Last November the College of Medicine of the Medical University of South Carolina celebrated its sesquicentennial. When founded in 1824 it became the first medical school in what was to be the Confederacy. Many North Carolina physicians spent some productive winters in Charleston. Since it took more than a hundred years for North Carolina to get a four-year medical school to survive, we must salute the College of Medicine in Charleston for showing us the way and helping to make good country doctors when medical education was harder to come by.

Before leaving the subject of country doctors, it might be well to remember that we have at Bailey the Country Doctor Museum, where we can for a moment grasp something of the tincture of another time, recapture the mysterious smells and perplexing formulae of old remedies and revisit all the Dr. Leslies whose apprentices we are.

A LEGACY OF SERVICE

The recent death of Donald Koonce and Amos Johnson, both past presidents of the Medical Society, marked the end of more than a quarter of a century

during which their lives were distinguished by devotion and dedication of thought, time and energy to the health care of the citizens of North Carolina and the nation. Each was a man of strong character, exhibiting positive thinking and explosive temperament balanced by good humor, open mindedness and an innate dignity that enabled him to exercise rare qualities of leadership.

Donald Koonce initiated Public Relations Conferences for the Medical Society, later to be replaced by the current Officers Conference. He was a long time speaker of the House of Delegates and inaugurated the Reference Committee System proven so effective in the conduct of the business of the Society. His interest in cancer led him to establish a Cancer Detection Clinic in his home town of Wilmington, the first of a chain of such clinics in the state. He was appointed by Governor Moore as chairman of a "Commission to Study the Cause and Control of Cancer in North Carolina."

Amos Johnson, exponent of family practice, proud evangelist of community medicine and effective advocate of medicine in legislative halls, exercised unique qualities of leadership in health affairs. He gave himself unsparingly to the cause of medicine through the offices of the State Medical Society, as president of the American Academy of Family Practice and as a member of the Joint Commission on the Accreditation of Hospitals. He also had a period of service as a member of the Board of Trustees of the University of North Carolina.

Both Amos Johnson and Donald Koonce represented the North Carolina Medical Society for many years in the House of Delegates of the American Medical Association, each serving with distinction on many committees.

The death in Florida of a third former president of the Medical Society, James F. Robertson, occurred recently. Serving the society as president in 1949, he was a former Chairman of the Executive Committee of the American Cancer Society, Co-founder of the North Carolina Cancer Institute in Lumberton and Co-founder, with Donald Koonce, and director of the James Walker Memorial Hospital Cancer Clinic in Wilmington.

These three distinguished doctors leave to today's physicians and to future generations a legacy of effective and dedicated service, in the name of the profession, to the cause of health care.

J.S.R.

Emergency Medical Services



THE U.S. DEPARTMENT OF TRANSPORTATION AND EMERGENCY MEDICAL SERVICES

Dawson A. Mills, M.D.

**Chief, Enforcement and Emergency Services Division
National Highway Traffic Safety Administration
U.S. Department of Transportation
Washington, D. C. 20590**

The Highway Safety Act of 1966 brought the Department of Transportation (DOT) into the emergency medical services field. Eighteen standards have been developed to include Periodic Motor Vehicle Inspection, Driver Education, Alcoholic Countermeasures and Emergency Medical Services. The states are directed to institute programs to ensure compliance with these standards. This is, in contrast to the Emergency Medical Services System Act, a permissive act, in which the state may apply for certain benefits.

The EMS Standard that was developed has a threefold purpose: to detect the ill or injured, to treat them effectively and to transport them safely to a medical facility. There are eight specific requirements within the standard relating to training, communications, operations and evaluation.

The national medical community perceives health care as a continuum in which the individual is carried from his entry into the system until he has been treated, has recovered and has been rehabilitated and returned to his optimal state of health. Therefore, since transportation was such an important part, it seemed appropriate for this to be placed under the transportation agency.

The Department of Transportation broke the emergency medical service into four principal areas: trained manpower, transportation, communications and facilities. The training program became of great

magnitude and a great deal of effort was placed into this; however, one of the stumbling blocks has been that it has not, in general, been backed up with state statutes.

In the transportation area, ambulance design and configuration has been reasonably standardized. Although considerable effort has gone into air transportation, standardization for both fixed-wing and helicopter evacuation has not reached unanimous accord of how it should fit into the system, but the Military Assistance to Safety and Traffic (MAST) Program is now working at 18 sites using military helicopters to supplement land-based EMS systems.

In the area of communications, the Department of Transportation has worked with the Federal Communications Commission and recently has received a new series of frequencies in the ultra-high frequency band. A great deal of effort is being spent working with the states in developing a statewide EMS communications plan.

The long term goal of the DOT is to develop an adequate EMS system that would be available to all citizens.

The actual medical facilities are more in the province of the Department of Health, Education and Welfare than of the Department of Transportation, but evaluation has been very difficult to date partly because of unavailability or inadequacy of data.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," Vol. 4, No. 4, April, 1975, John M. Howard, M.D., Editor. Original article may be obtained from the Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

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WHAT? WHEN? WHERE? In Continuing Education

July 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For information."

PROGRAMS IN NORTH CAROLINA

July 20-25

Annual meeting of the Southern Obstetric and Gynecologic Seminar, Inc.
 Place: Great Smokies Hilton Hotel, Asheville
 Fee: Members, no fee; non-members, \$50
 Credit: 21 hours
 For Information: W. Otis Duck, M.D., Drawer F, Mars Hill 28754

July 21-26

Postgraduate Course in Radiology
 Place: Atlantis Lodge, Atlantic Beach (near Morehead City)
 Fee: \$150; designed for radiologists, but open to all physicians. Enrollment limited to 75
 Credit: 30 hours
 For Information: Robert McLelland, M.D., Department of Radiology, P. O. Box 3808, Duke University Medical Center, Durham 27710

September 5-6

North Carolina Chapter of the American Academy of Pediatrics and The North Carolina Pediatric Society—Annual Meeting
 Place: Blockade Runner, Wrightsville Beach
 For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 12-13

Two Days of Stroke
 Fee: \$50
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 12-13

1975 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery
 Main emphases will be upon Trophoblastic Disease, Vulvar Malignancies, and Endometriosis. Invited guests include Dr. John Lewis, New York, Dr. George Morley, Ann Arbor, Michigan, and Dr. Hugh Shingleton, Birmingham, Alabama.
 For Information: W. T. Creasman, M.D., Director, Gynecologic Oncology, Box 3079, Duke University Medical Center, Durham 27710

September 12-13

North Carolina Association of Blood Bankers Annual Convention
 Place: Sheraton Inn, Charlotte
 For Information: Roy A. Weaver, M.D., President, P. O. Box 2000, Cape Fear Valley Hospital, Fayetteville 28302

September 12-14

Legislative Workshop: this institute will bring together members of the North Carolina Medical Society and persons from the legislative and executive branches of North Carolina state government, so that North Carolina physicians may gain a better understanding of the process of government
 Place: Center for Continuing Education, Appalachian State University, Boone
 Sponsors: North Carolina Medical Society and Smith Kline & French Laboratories
 For Information: Stephen C. Morrisette, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 18-21

Invitational Assembly for Advanced Urology: Pediatric Urologic Problems
 Place: Pinehurst Hotel and Country Club, Pinehurst
 Fee: \$135
 Credit: 18 hours
 For Information: James F. Glenn, M.D., Division of Urology, Duke University Medical Center, Durham 27710

September 19

Child Abuse and Neglect Seminar
 Credit: 6 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 24-27

North Carolina Medical Society Annual Committee Conclave
 Place: Mid-Pines Club, Southern Pines
 Regular meetings will be scheduled for the chairman and members of almost all regular committees of the Medical Society. Committee members should plan to be present if at all possible.
 For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 25-27

Fifth Annual Seminar in Medicine
 Fee: \$100
 Credit: 15 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar
 Place: Charlotte Memorial Hospital Auditorium
 Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital
 Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children
 For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists Annual Conference
 Place: Benton Convention Center, Winston-Salem
 Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education, scientific exhibits and a display of commercial equipment.
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 10th

27th Annual Physicians' (Heart) Symposium
 Place: Babcock Auditorium, Bowman Gray School of Medicine
 For Information: Mrs. Betty Cauthen, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103

October 17-18

Seventh Annual Duke Symposium on Orofacial Anomalies
 Credit: 12 hours; AAFP credit applied for
 For Information: Raymond Massengill, M.D., Department of Surgery, P. O. Box 3523, Duke University Medical Center, Durham 27710

October 17-18

Office Management of Marital and Sexual Problems
 Fee: \$100 (includes spouse)
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 30

Diagnosis and Treatment of Sleep Disorders
 Credit: 2 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 3-7

Current Concepts in Pediatric Radiology
 Place: Pinehurst Hotel, Pinehurst
 Program: There will be a systems oriented format covering Cardio-pulmonary diseases on Monday, Gastro-intestinal diseases on Tuesday, Genito-urinary diseases on Wednesday and Musculoskeletal diseases on Thursday. "with Friday left for miscellaneous disorders."
 Credit: 25 hours
 For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham 27710

November 7

Scientific Session, Alumni Association, Bowman Gray School of Medicine
 Credit: 5 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 21-22

Second Annual Arthritis Symposium
 Fee: \$35
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 5-6

Endoscopy Workshop
 Place: Berryhill Hall
 Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine
 Fee: \$75
 For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

December 5-6

Family Practice Workshops
 Credit: Credit hours have not yet been determined
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient
 Fee: \$100
 Credit: 15 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

ITEMS OF SPECIAL INTEREST

October 4-7

Southern Psychiatric Association Annual Meeting
 Place: Houston Oaks, Houston, Texas
 For Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

November 3-8

Course in Laryngology and Bronchoesophagology
 Program: Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.
 For Information: Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612

PROGRAMS IN CONTIGUOUS STATES

August 4-8

Topics in Internal Medicine—Third Annual Beach Workshop
 Place: Myrtle Beach Hilton, Myrtle Beach, South Carolina
 Sponsors: Divisions of Continuing Education, Bowman Gray, Duke and UNC Schools of Medicine, and the Medical College of South Carolina
 Fee: \$100
 Credit: 20 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

August 21-23

Fundamental Approaches to Cardiovascular Therapeutics
 Place: Hilton Head Inn, Hilton Head, South Carolina
 Sponsors: North Carolina Heart Association; South Carolina Heart Association; American Heart Association; Duke University Division of Cardiology
 Fee: \$100 for members of the Heart Association; \$150 for non-members
 Credit: 10½ hours; AMA Category 1, and AAFP approved
 For Information: American Heart Association, 44 East 23 Street, New York, New York 10010

September 7-13

General Practice Review Course
 Place: Mills Hyatt House Hotel, Charleston, South Carolina
 Fee: \$150
 Credit: 38½ hours AAFP credit
 For Information: Dr. Vince Moseley, Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

October 20-21

Tennessee Valley Medical Assembly annual meeting
 For Information: Clifton R. Cleaveland, M.D., Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association
 Place: Miami Beach, Florida
 For Information: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205

December 7-10

Structure-Function Correlations in Cardiovascular Disease
Place: Williamsburg Conference Center, Williamsburg, Virginia
For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

Mrs. Charles L. Herring, the new President of the Auxiliary, brings greetings.

This is the beginning of another year for the North Carolina Auxiliary to the North Carolina Medical Society. This is a great year indeed as our country celebrates its bicentennial birthday. To help celebrate, many auxiliaries as well as the medical societies are working on histories of their organization. We will be joining with the state medical society to help celebrate this year. You will hear more about this in later issues of this journal.

In the coming year, there are four areas I would like to emphasize. One is that we be great ambassadors for

health and our husbands—to help our husbands—educate our communities in health problems and to provide a means of educating the children in health careers. I feel this is the only way we can alleviate the shortage of help in these fields. Second is that we communicate with each other, not only as husbands and wives, but within the auxiliary of the society. Your problems are our problems and we are the North Carolina medical auxiliary because of you. We must be familiar with the problems such as malpractice, PSRO, utilization review committee and the other pressing issues. We are not basically woman's libbers; we are concerned because you are our husbands and we are willing to help you and the community we live in.

I encourage more communication between the county medical societies and auxiliaries. Let us work together to be better ambassadors for this great country in medicine and health.

Third is the area of health, community and family education—all interrelated in working together to achieve those goals in your community. We must strive to upgrade the health curriculum in our schools—working with various organizations related to the health problems and with the department of instruction. This way we can achieve this goal. We must cooperate and participate with other organizations in educating families and communities in self-examination breast courses, cardiac resuscitation courses,



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high blood pressure clinics, cervical cancer clinics and other valuable classes and clinics within the community.

The fourth area is continuing support in giving to AMA-ERF and to our Student Loan Fund. These projects provide funds for students who need help to continue education in the medical field. With the increased cost of living, we can see why we have many applicants needing help with their education. With the AMA-ERF funds, deans of medical schools welcome this contribution to help them in various ways within their institutions. This money is given with no specifications requested and may be used in any area that they desire. An article from the deans of the medical schools will appear in a later issue describing how they have used the money. Please continue to support these two projects as all have done so generously in the past.

We thank you for this opportunity to chat with you. Please look at our articles every month to learn what your auxiliary is doing.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Roy T. Parker, chairman of the Department of Obstetrics and Gynecology, has assumed the national presidency of the American College of Obstetricians and Gynecologists.

During his one-year term as 26th president, Parker will be responsible for the executive direction of the professional association which has nearly 17,000 members plus 12,000 nurse colleagues.

At administration-of-oath ceremonies in Boston, Parker was escorted before the college by three men who have been closely associated with his personal and professional life.

They were Dr. F. Bayard Carter, Parker's predecessor as chairman and the man for whom a professorship in the department—which Parker now holds—was named; Dr. James M. Ingram of Tampa, who served under Parker as a resident here; and Dr. Sam L. Parker of Kinston, his brother.

A native of Pinetops, Edgecombe County, Parker received his undergraduate degree at the University of North Carolina in 1941 and his M.D. degree at the Medical College of Virginia in 1944.

During World War II and again during the Korean War he served as a U. S. Navy physician.

Following a brief private practice at the Kinston Clinic, Parker was appointed to the Duke faculty in 1955.

* * *

Dr. E. Harvey Estes, chairman of the Department of Community Health Sciences, has received the 1975

Rondomycin®

(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin® (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin® (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb./day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

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Distinguished Internist Award from the American Society of Internal Medicine.

The society cited Estes for a number of innovations he has been instrumental in bringing to Duke.

Ten years ago, Estes and Dr. Eugene A. Stead Jr. established the first physician's associate program in the country. That program has spawned more than 40 similar ones across the country and now boasts 194 graduates.

Estes set up the Duke-Watts Hospital Family Practice Program, in which resident physicians in family medicine get first-hand experience at both institutions. He also organized satellite clinics in lower income communities in and outside Durham.

He was nominated for the national honor by Dr. John L. McCain of Wilson, president of the North Carolina Society of Internal Medicine.

McCain praised Estes as an "outstanding physician and scientist" known not only for ably "teaching to students the technical aspects of our profession but also for conveying to the students his genuine interest in their personal lives and development."

Estes gave up a career in heart research to lead Duke's fledgling Department of Community Health Sciences in 1966.

Estes received his B.S. and M.D. degrees from Emory University. After serving a residency at Duke, he joined the faculty here in 1953 as an instructor in medicine. Eight years later, he was a full professor.

* * *

A researcher at the medical center who is studying painless techniques for diagnosing and describing heart disease has been named Howard Hughes Assistant Professor of Surgery.

Dr. Robert L. Jones, currently a teaching scholar and associate in the Department of Surgery, assumed the new position in July.

The appointment, which includes full salary and research support, was made by the Howard Hughes Medical Institute of Miami.

Jones' research involves using radioactive isotopes to trace blood flow through the heart's chambers so that patients with diseased hearts may be more easily distinguished from normal individuals.

Jones earned a B.S. degree from Harding College in Searcy, Ark., in 1961. He received his M.D. from Johns Hopkins School of Medicine in Baltimore, Md., in 1965 and since that time he has served two years in the U. S. Air Force and completed a surgical residency here.

* * *

Two physicians will be part of a Duke University group that has been invited for an 18-day visit to China in October and November.

They are Dr. William G. Anlyan, vice president for health affairs, and Dr. James B. Wyngaarden, chairman of the Department of Medicine. Anlyan said the visit will mark the first time a university has been able to send a cross-section of senior people to visit institutions of higher learning in the People's Republic of China.

"Up to now," Anlyan said, "very highly focused groups such as the American Medical Association and the Institute of Medicine have visited there, but there has not been a cross-sectional delegation from a major university."

The team, scheduled to visit from Oct. 24 to Nov. 10, will be headed by Duke President Terry Sanford, who said the focus of the trip will be an interchange of ideas and knowledge in medicine, medical care, science and education. The trip will include visits to Canton, Peking, Shanghai and Nanking. Sanford said no university funds will be used to finance the trip.

Others in the group will include Dr. Kenneth Pye, dean of the Law School; William Green, the university's director of public relations; Dr. Terry Johnson, professor of botany; and Dr. Orrin Pilkey, a professor of geology.

* * *

Two faculty members and a resident were singled out by students in the School of Medicine for their excellence in teaching this year.

Dr. F. Stephen Vogel, professor of pathology, Dr. Bruce W. Dixon, assistant professor of hematology, and Dr. Michael Fried, chief resident in obstetrics and gynecology, were chosen as the recipients of Golden Apple Awards which are presented annually to outstanding educators in basic sciences, clinical sciences and house staff categories.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

An international meeting has been named in honor of Dr. Hugh B. Lofland, Bowman Gray professor of pathology, who died April 2. The name of the annual workshop on Arterial Wall Metabolism has been named the Lofland Conference on Arterial Metabolism.

The meeting was organized in 1967 in response to an idea by Dr. Lofland that there needed to be some mechanism for the informal dissemination of data relative to the metabolism of the arterial wall in atherosclerosis. The eighth annual workshop was recently held at Bowman Gray, with 100 scientists from the United States and three foreign countries attending.

* * *

Dr. Lawrence R. DeChatelet, associate professor of biochemistry, received the Award for Teaching Excellence during the medical school's annual award ceremony.

The recipient of the award is selected by a committee of students, faculty and administration of the medical school.

Dr. Paul B. Comer, assistant professor of anes-

thesia, and Dr. Robert C. McKone, associate professor of pediatrics, received Clinical Faculty Teaching Citations. Dr. Nitya R. Ghatak, associate professor of pathology, received the Basic Science Teaching Award.

* * *

The 1975 graduating class at Bowman Gray dedicated its yearbook, "The Gray Matter," to Dr. A. Sherrill Hudspeth, associate professor of surgery.

In honoring Dr. Hudspeth, the seniors referred to his "eagerness to teach . . . determination to further the knowledge of medicine . . . total concern for his patients . . . commitment to man's right to live."

The yearbook also includes pages dedicated to Dr. Weston M. Kelsey, former professor and chairman of the Department of Pediatrics, and Dr. Carl M. Cochrane, former professor of psychology, both of whom died during the past year.

* * *

Fifty physicians from North Carolina, Kentucky and Tennessee have received appointments to the medical school's part-time faculty in the Department of Community Medicine. The physicians are participants in the Department of Community Medicine's preceptorship training program through which Bowman Gray medical students receive part of their training in the offices of primary care physicians, in clinics and in small community hospitals.

Appointed clinical assistant professors were Dr. H. Dean Belk, Winston-Salem; Dr. Elam S. Kurtz, Lansing; Dr. Carroll Hardy Long, Johnson City, Tenn.; and Dr. John W. Nance, Clinton.

Those appointed lecturers were Dr. Frederick W. Graham Jr., Asheboro; Dr. Ernest H. Stines, Dr. George W. Freeman, Canton; Dr. Latham C. Peak, Dr. Glen C. Newman, Dr. Henry J. Carr Jr., Dr. Frank W. Leak, Dr. William L. Owens, Dr. Bruce F. Caldwell, Dr. J. Cooper Howard Jr. and Dr. Donn A. Wells, Clinton; Dr. Wayne H. Stockdale, Goldsboro.

Also, Dr. Walter McLeod and Dr. Duane Budd, Johnson City, Tenn.; Dr. George Hancock, Lenoir; Dr. D. E. Ward Jr., Lumberton; Dr. Bob M. Foster, Dr. Albert R. Hartness and Dr. George D. Kimberly, Mocksville; Dr. Robert S. Cline, Sanford; Dr. George H. Givens Jr., Taylorsville; Dr. David R. Williams, Dr. Charles F. Gilliam and Dr. Hestley D. Stepp, Thomasville.

Also, Dr. Hervey B. Kornegay Jr. and Dr. Robert H. Shackelford, Mt. Olive; Dr. H. Gene Washburn, Boiling Springs; Dr. John L. McCain, Wilson; Dr. Gordon Hollins, Harlan, Ky.; Dr. W. Donald Moore, Coats; Dr. Wesley F. Phillips and Dr. S. Leo Record Jr., Kernersville; Dr. John F. Munroe, Whiteville; Dr. Carl J. Hiller, Dr. Edward J. Nedbel, Dr. J. B. Warren, Dr. Irving R. Stockton, Dr. Francis P. King, Dr. Robert P. Holmes III, Dr. Charles H. Ashford Jr., Dr. John D. Harrah, Dr. James N. Blackerby and Dr. Zack J. Waters Jr., New Bern; Dr. Richard W. Hudson, Bayboro; and Dr. Neil C. Bender and Dr. Rick A. Moore, Pollacksville.

* * *

Dr. David L. Kelly, associate professor of neurosurgery, has been elected president-elect of the North Carolina Neurosurgical Society. He also has been appointed chairman of the public relations committee of the American Association of Neurological Surgeons for 1976.

* * *

Dr. James F. Martin, professor of radiology, is the new president of the Eastern Radiological Society. He succeeds Dr. M. Paul Capp, professor and chairman of the Department of Radiology at the University of Arizona College of Medicine.

* * *

Bowman Gray has become one of the first medical schools in the nation to begin an active program of collecting and preserving its oral, written and pictorial history.

The development of an official archives has been authorized and funded by the school.

* * *

Dr. Vardaman M. Buckalew Jr., professor of medicine and physiology, has been appointed to the Special Training Review Study Section of the National Institute of Arthritis and Metabolism.

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Dr. Clark E. Vincent, professor of sociology and chairman of the Department of Medical Social Science and Marital Health, has been invited to serve as a member of the Social Problems Research Review Committee of the National Institute of Mental Health for a four-year period.

* * *

Dr. William D. Wagner, assistant professor of comparative medicine, has been appointed interdepartmental coordinator for the Interdisciplinary Program in Comparative and Experimental Pathology, succeeding the late Dr. Hugh B Lofland, Jr.

* * *

Dr. Hal T. Wilson, medical director of the physician's assistant program, has been appointed to the American Society of Internal Medicine Allied Health Committee, the Public Relations Committee of the North Carolina Medical Society, and was named consultant for the American Academy of Physician Assistants for grant proposals.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Carl W. Gottschalk, kidney specialist at the University of North Carolina at Chapel Hill, was recently elected to the National Academy of Sciences (NAS).

A Kenan Professor of Medicine and Physiology, Dr. Gottschalk becomes president of the American Society of Nephrology in November, 1975.

Eighty-four scientists from all over the nation were added this year to NAS's 1,134 membership.

* * *

Dr. William Paul Biggers of the UNC School of Medicine at Chapel Hill has won the 1975 Central Carolina Bank Excellence in Teaching Award.

The student body selected the associate professor



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* * *

Dr. George M. Himadi, UNC associate professor of radiology, has won the Professor Award presented by the senior class of the UNC School of Medicine at Chapel Hill. The award is given annually to the professor whose "willingness, understanding and ability" has contributed most to the graduating class's medical education.

* * *

Glenn Wilson, associate dean for community medical care, UNC-Chapel Hill, has been named a member of the advisory panel on national health insurance to the subcommittee on health of the House Committee on Ways and Means.

* * *

The student body of the UNC School of Medicine at Chapel Hill honored faculty, house staff and fellow students at the annual student-faculty day.

The second-year class presented the Medical Basic Science Teaching Award to Lloyd Robert Yonce, associate professor of physiology. Dr. Richard Walsh, a resident in medicine, was named recipient of the Henry C. Fordham award by the senior class.

Dr. Harold Calloway Pollard, III, a 1974 graduate of

the UNC School of Medicine, was presented the Outstanding Intern Award. Francis Sellars Collins, a second-year student from Staunton, Va., received the William deB. MacNider Award as the sophomore medical student who possesses the various intangible traits of character typified by Dr. "Billy" MacNider during his 51 years as a teacher and physician at UNC.

* * *

Pamela Upchurch Joyner, formerly staff pharmacist at Wake County Memorial Hospital, Raleigh, has been appointed pharmacy coordinator in the Wake Area Health Education Center (AHEC) in Raleigh.

In her new position Joyner will provide leadership for numerous pharmacy education programs for undergraduates, graduates and practicing pharmacists in the Wake AHEC service area, which includes Franklin, Granville, Johnston, Lee, Vance, Wake and Warren counties.

* * *

Dr. James H. Scatliff challenged the graduating class of the University of North Carolina School of Medicine to "do some real doctoring and listen to hearts as well." Dr. Scatliff spoke at graduation exercises May 11 in Memorial Hall on the UNC-Chapel Hill campus. Eighty-three students received the doctor of medicine degree. Five were awarded the degree with honor. Twenty-two members of the class, who

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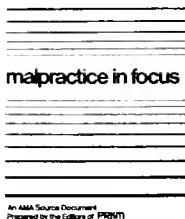
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received their degrees in December, participated in the hooding ceremony.

Dr. Scatliff, chairman of the department of radiology at the School of Medicine, told the graduates "as physicians we have to be more than super informed and super technicians but (also) concerned, compassionate and caring people."

* * *

The latest trends and advances in contraceptives, sterilization, pregnancy termination, infertility and counseling were examined here May 12-13, during a family planning seminar at the Carolina Inn.

More than 100 physicians, nurses, health educators and social workers attended the two-day program sponsored by the Schools of Medicine and Nursing, and the Department of Obstetrics and Gynecology at the UNC-Chapel Hill.

* * *

The Josiah Macy Jr. Foundation has named Dr. John H. Schwab of the UNC School of Medicine a Faculty Scholar for 1975-76.

Dr. Schwab is one of 30 scientists chosen to participate in the program, established two years ago to "recognize and reward excellence in academic medicine." The program was created to encourage scholars to spend 6-12 months studying and conducting research in a fresh environment. Its secondary

purpose is fostering international exchange of medical knowledge.

Dr. Schwab, professor of bacteriology and immunology, will study how bacteria influence aging. He leaves August 1 to spend a year at the Institute for Experimental Gerontology in The Netherlands.

* * *

Professor Arthur C. Stern and graduate student Werner Martin at the UNC-Chapel Hill have written two volumes on world air quality published by the Office of Research and Development, U.S. Environmental Protection Agency (EPA) in Washington, D. C.

* * *

Dr. John K. Spitznagel, professor of bacteriology and immunology at the School of Medicine, UNC-Chapel Hill, has been elected vice chairman of the Immunology Division of the American Society for Microbiology.

* * *

Dr. Christopher C. Fordham, III, dean of the UNC School of Medicine at Chapel Hill, has been appointed to the Executive Council of the Association of American Medical Colleges (AAMC). Dean Fordham is a representative from the Council of Deans.

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GRAENUM R. SCHIFF, M.D.

Dr. Seymour M. Blaug, dean of the UNC School of Pharmacy at Chapel Hill, announced the receipt of a \$28,186 Department of Health, Education and Welfare General Research Support Grant.

* * *

Dr. Claude Piantadosi, head and professor of the Division of Medicinal Chemistry at the UNC School of Pharmacy at Chapel Hill has been elected Fellow of the American Pharmaceutical Association Academy of Pharmaceutical Sciences.

News Notes from

EAST CAROLINA UNIVERSITY

East Carolina University and the family of the late Dr. Amos N. Johnson of Garland recently announced establishment of a memorial fund to strengthen family practice in the ECU School of Medicine.

Dr. Johnson, a rural family practitioner for more than 40 years, died earlier this year.

Announcement of the Amos Neill Johnson Memorial Fund in his honor was made jointly by his widow, Mrs. Mary Porter Johnson, on behalf of the family, and by ECU Chancellor Leo W. Jenkins and Dr. Edwin Monroe, Vice Chancellor for Health Affairs, on behalf of ECU.

The fund will be established within the East Carolina University Foundation for Health Affairs, and will be used to enhance development of a strong Department of Family Practice in the ECU medical school.

Proceeds from the fund may be used to establish a memorial chairmanship or professorship, for recruitment of top-quality faculty in the department, for enhancing state operating funds for the department, for family practice student or resident financial aid, and for other similar needs.

The fund will permit contributions from individuals or organizations on tax-exempt basis.

Dr. Johnson was an alumnus of Duke University and received the M.D. degree from the University of Pennsylvania in 1933. After serving a medical internship at Jackson Memorial Hospital in Miami, Fla., he began his career in private general practice in Garland and joined the staffs of Sampson County and Bladen County Memorial Hospitals. He became a member of the Duke University medical faculty in 1944.

Dr. Johnson was active in medical organizations and held several elective and appointive offices, including president of the N. C. Medical Examiners and medical advisor to the U. S. Dept. of Health, Education and Welfare and the N. C. Board of Mental Health. He was also a member of three N. C. Governors' Commissions.

In addition, he served as president and board member for the American Board of Family Practice, state and national president of the American Academy

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

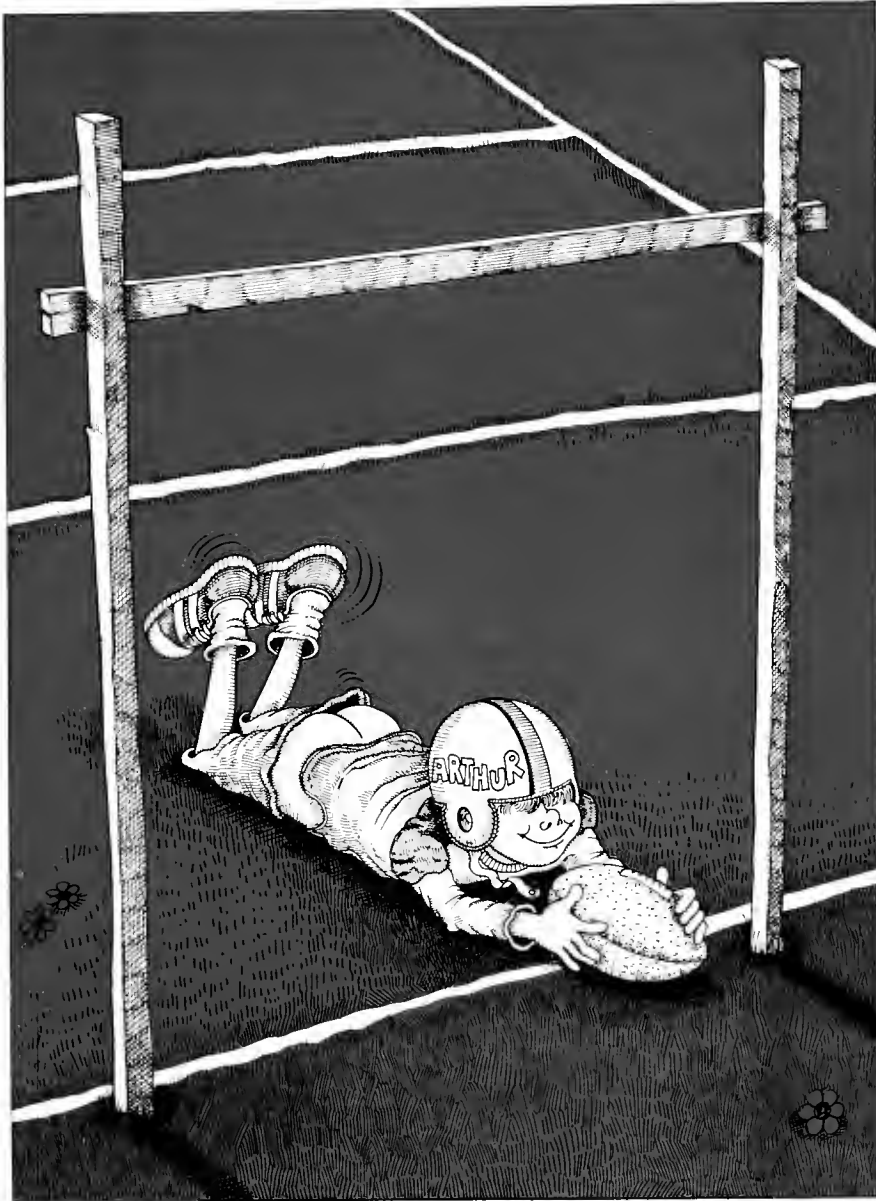
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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ORAL SUSPENSION

of General Practice, and member of the American Medical Association's Hospital Accreditation Commission.

He was president of the N. C. Medical Society in 1960-61.

Dr. Jenkins said the memorial would be a "fitting" tribute to "one of the truly great champions of rural family practice to serve the needs of the people of North Carolina."

"Amos Johnson was among our strongest supporters and a constant source of encouragement and in-

spiration in the long struggle to establish a school of medicine at East Carolina University," Jenkins said. "It is especially appropriate that such a fund be established to further his aspirations that emphasis be placed on primary health care delivery for rural North Carolina—the need for family doctors.

Dr. C. Clement Lucas Jr., of Edenton, a close friend and protege of Dr. Johnson and a past president of the National Assn. of Medical Students, assisted Mrs. Johnson and the family in arranging for the memorial fund.

Month in Washington

The American Medical Association has urged all members of the House of Representatives to oppose two key provisions of a health manpower bill that would extend federal control over medical education.

The controversial sections of the bill that won easy passage in the House Interstate and Foreign Commerce Committee would:

- * Establish federal control of the number and location of medical residencies.

- * Require all medical students to repay the federal government for U.S. aid to the school.

In a letter dispatched to the 435 lawmakers in the House, the AMA stressed continued support for federal assistance to medical schools and students. However, the association said "strong objection is raised" to "certain new concepts" that would impose restrictions on students and on residencies.

The health manpower bill won approval by the House Commerce Committee with the two disputed provisions by roughly a 2-1 margin. The bill authorizes \$1.7 billion for aid to medical, dental, nursing and other schools with a \$2,100 per student capitation subsidy by the federal government for medical students.

A House vote is expected about mid-summer. The Senate has not yet considered the bill.

The AMA told House Members:

"These requirements—that the students, as a personal obligation, repay to the federal government those amounts which the government has given to the schools—are without precedent and are discriminatory against health professions' students. These conditions are not imposed on students in other fields, nor should they be. This amounts in effect to a forced loan required of all health professions' students under the bill. Once again, through the service requirements attached to the loan forgiveness features, the low income or disadvantaged student would carry a dispro-

portionate burden. The best way to attract individuals to shortage areas is through mechanisms which allow the individual voluntarily to commit himself to service in a needy area. As to government programs, this could be done through such programs as the National Health Service Corp., scholarships for service in shortage areas, loan forgiveness, or other incentive programs.

"It should not be done through a program where all students are under the burden of insuring that the federal assistance given to the school is repaid by the student," the AMA said.

The proposed control of medical residency training programs amounts to "the rationing of medical education . . . and poses many threats to our quality education system," according to the AMA.

The bill would establish two agencies: one would be responsible for accrediting medical residency training programs in the U.S.; the other to establish the number of positions which could be filled in each residency program.

The aggregate limit on the number of positions which could be available in years 1978, 1979 and 1980, would be an amount equal to 155 percent, 140 percent and 125 percent, respectively, of the estimated number of graduates from accredited U.S. schools of medicine in the year preceding.

Priority for designation would be the Liaison Committee for Graduate Medical Education of the Coordinating Council on Medical Education (CCME) as the accrediting agency, and the CCME as the agency to establish the number of residency positions. The latter agency would determine the geographic distribution of residency training positions, the number of positions in each program and an allocation of positions among the various specialties. In the absence of designation of the named agencies, the activities would be undertaken by another organization

designated by the HEW Secretary.

Included with the AMA letter to the Congressmen was a copy of an article in the Journal of the Tennessee Medical Association by Tom Nesbitt, M.D., Speaker of the AMA House of Delegates and Chairman of the CCME. Dr. Nesbitt wrote that a question posed by the legislation is "of the private voluntary sector remaining voluntary, as opposed to its becoming an arm of the federal government, subject to its bureaucracy and its political influences and controls."

But the fight of the AMA and other medical organizations, including the Association of American Medical Colleges, to strike or limit the two controversial sections of the bill appears to be an uphill battle.

If the sweeping service requirement of the bill is retained, the impact on American medical practice would be marked with more than 10,000 young physicians yearly heading into rural areas, inner-city slums, and other shortage areas. Furthermore, the federal government—military, public health service and Veterans Administration—would have recruiting worries erased.

* * *

Aroused by growing complaints besides those of the AMA that government is superseding Congressional intent in issuing control regulations in the Medicare program, the House Ways and Means Committee has slated an unusual one-day session to "examine these policies."

The so-called "public oversight" session will deal with the controversial Utilization Review Regulations under court challenge by the AMA (the first round won by the AMA May 27, 1975), the proposed rules governing Medicare reasonable charges and economic indices, reduction of inpatient payment for hospital routine service costs from the 90th percentile to the 80th percentile, and elimination of the special nursing differential for reimbursement to hospitals and skilled nursing facilities.

"Serious and widespread concerns have been raised about the policies in these regulations, including the question whether the special characteristics of small rural hospitals are adequately taken into account," said Subcommittee Chairman Dan Rostenkowski (D-Ill.). "The Subcommittee intends to examine these policies and their implementation in the light of Congressional intent relative to the conduct of the Medicare program."

The HEW Department's plan to tie physicians' Medicaid reimbursement to a national economic index has been assailed by the AMA as "inequitable and unfair." The "invidiousness" of imposing economic controls on one sector of the economy "is intensified when consideration is given to the fact that the controls and limits on the government financial contribution towards payment of the medical care of a Medicare beneficiary set arbitrary limits on prevailing charges, and thus shift an increasing burden onto the Medicare beneficiary," said the AMA.

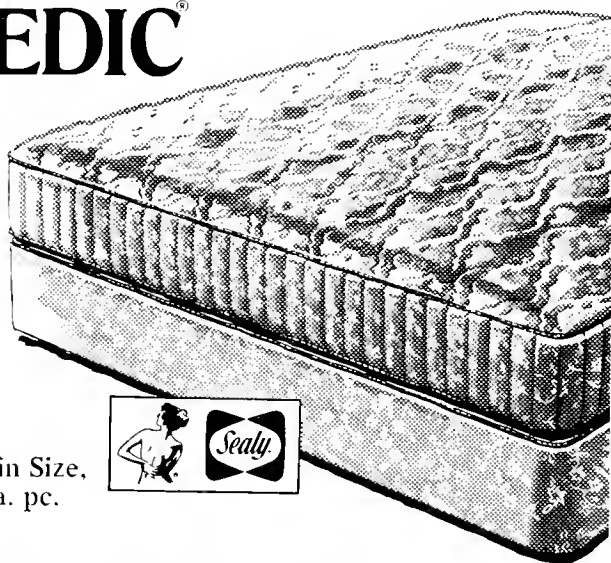
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In a statement, AMA Executive Vice President James H. Sammons, M.D., urged that the regulations be withdrawn. Dr. Sammons noted that the two-year time lag already involved in the recognition of physicians' fees "is in itself unique and has operated in such a way that Medicare fee recognition has long lagged behind current trends in physicians' fees."

There is no justification in either the law or its legislative history for the imposition of "a national economic index," said Dr. Sammons. The statement in the proposed regulations that increases are to be "fair to all concerned and follow, rather than lead, any inflationary trends" is contradictory and "when considered in the context of the history of restrictions and limitations placed upon Medicare fees, is an affront to the physicians who have cooperated through a long period during which there has been imposition of arbitrary freezes and targeted economic controls," the AMA official said.

Also attacked by the AMA was the lower reimbursement limit for hospital Medicare costs, to 80 percent from the present 90 percent. "The imposition of arbitrary ceilings on hospital revenues affects the quality of service available to Medicare patients" and may force some hospitals to treat Medicare patients at a loss, Dr. Sammons said.

"Fixing a ceiling limitation on reimbursement by bed size and location for all hospitals does not establish the existence—or lack—of efficiency," said the AMA. "This simplistic approach provides no assur-

ance that inefficiency will be corrected or that efficient operations will be rewarded. The proposed system simply applies pressure to reduce per diem costs to a set dollar amount without regard to how such reductions may be attained, and appear to be predicated upon ease of administration rather than the elimination of unnecessary costs flowing from inefficient operation."

* * *

State legislators from across the nation meeting in Washington on malpractice were told that "massive federal intervention" would cause "irreparable harm," probably increase overall costs, lead to federal strings attached, and simply attempt to "paper the problem over with dollars."

HEW Assistant Secretary for Health, Theodore Cooper, M.D., told the National Conference of State Legislatures that he is confident the legislators "are not about to relegate to the U.S. Government the states' responsibility over insurance and medical practice."

The meeting was arranged by the National Conference and the newly formed Health Policy Center of Georgetown University to discuss malpractice insurance "as the perfect example of the need for federal-state coordination," in the words of Don Herzberg, Dean of Georgetown's graduate school.

The sponsoring organizations had hoped that some form of consensus and call for action might emerge

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from the three-day session, but the state lawmakers could only agree at this time that the situation was serious and that the remedies in sight appeared to be short-term ones. Several spoke of the difficulties in persuading consumer advocates in their state legislatures that a crisis exists that affects patients as well as physicians or that legislative remedies were not aimed at bailing out hard-pressed insurance companies.

Dr. Cooper urged the states to enact new laws covering professional liability. He said there is need for public education to the fact that there are unavoidable limitations to medical care, that not all injuries are in fact malpractice, that people are not entitled to compensation simply because they have suffered.

* * *

Legislation to require all clinical laboratories to meet specified federal standards is slated for a close Congressional look this year. Physicians' private office labs could be covered under draft legislation if work is done for more than one physician.

The measure backed by Sens. Jacob Javits (R-N. Y.) and Edward Kennedy (D-Mass.) gives some discretion to HEW on the sweep of the standards coverage. However, all labs, including those now considered strictly intra-state, would have to meet federal standards.

The program would be administered at the state level by a single state agency which could issue licenses in the name of the federal government.

The Center for Disease Control, U.S. Public Health Service, would provide assistance and check on progress of state efforts, but a new HEW Office of Clinical Laboratories would be the chief supervisor.

The state programs could rely on professional accrediting and testing programs, but spot-checking and testing by the federal agency is authorized.

The licensing standards cover quality control, record-keeping, personnel, and participation in proficiency testing.

Many features of the legislation are certain to arouse controversy.

* * *

The American Society of Internal Medicine (ASIM) has agreed to participate in the Federated Council for Internal Medicine—provided that policy decisions by the Council are made only by unanimous vote of the four member groups.

The Council would attempt to coordinate policies and actions of the four organizations in the internal medicine field—ASIM, the Association of Professors of Medicine, the American Board of Internal Medicine, and the American College of Physicians.

The ASIM agreement to participate came at its annual meeting in Washington.

According to a report by the ASIM's Board of Trustees, the Council has the potential to:

* * Identify internal medicine as a unified community of physicians capable of collective action.



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* *Improve the quality of debate and decisions on major public issues of concern to internal medicine; and provide a medium to establish a consensus within the specialty in advance of public pronouncements.

ASIM also voted to support a national health insurance measure that would cover the costs of catastrophic illness. "This insurance should be supplied by private carriers to the greatest extent possible," the resolution declared.

Comprehensive coverage for all medical care needs would be inflationary and add unnecessary stress to an already over-burdened economy, according to the resolution.

E. Harvey Estes, M.D., Director of Duke University's Department of Community Health Sciences, was named "Distinguished Internist of the Year" by ASIM.

William R. Felts, M.D., an internist and rheumatologist practicing in Washington, D. C., was elected ASIM President-Elect. Dr. Felts is Director of the Division of Rheumatology at George Washington University Medical School. He has been one of the Society's Trustees since 1969 and served as Chairman of its Liaison Council. He will serve as President following the one-year term of Ralph F. Reinfrank, M.D., who assumed office during the meeting.

Book Reviews

Clinical Perinatology. 1st edition. Silvio Aladjem, M.D. and Audrey K. Brown, M.D. (editors). 492 pages. Price \$39.50. Saint Louis: The C. V. Mosby Company, 1974.

Clinical Perinatology is an excellent book for obstetricians, neonatologists, and all others involved in this "exciting, young, vigorous specialty," as Virginia Apgar described perinatology.

Beginning with a short philosophical overview from the late Dr. Apgar, the book continues with excellent and relevant discussions by some of the field's most illustrious practitioners. The discussions include detailed descriptions of the physiology and pathophysiology of pregnancy, diagnostic and therapeutic approaches to the fetal patient, perinatal genetic studies and counseling, legal and ethical considerations, perinatal infections and pathology, placental function and malfunctions, labor stresses, fetal and neonatal homeostasis, and perinatal mortality and morbidity.

There were several chapters of particular interest to this reviewer. "Perinatal Genetic Studies and Counseling" by Carlo Valenti not only contains an objective appraisal of the progress and limitations in the field but also provides thoroughly fascinating photographs of sonograms, echograms, amniograms, and endo-amnioscopic visualizations. The chapter, "Perinatology: Legal and Ethical Considerations," by Irving Ladimer, S. J. D., is especially relevant in this age of human triage "life-boating," and situational ethics. In this chapter are found discussions of medical practice and malpractice, abortions, perinatal studies, genetic counseling, and rules for experimentation. Generally complete and certainly absorbing, the chapter has one flaw—less than one of its 31 pages is devoted to the impact of the women's movement on

the practice perinatology, a phenomenon which deserves more consideration.

Samuel Taylor Coleridge aptly described the fetal condition when he wrote: "The history of man for the nine months preceding his birth would probably be far more interesting and contain events of greater moment, than all the three score and ten years that follow it." Silvio Aladjem's "The Fetus as a Patient" and June Brady's "Homeostatic Adjustments of the Fetus and the Neonate" deal with these "events of greater moment." These chapters provide interesting discussions on prenatal diagnosis and treatment and postnatal cardiopulmonary, renal, and metabolic adaptations.

Finally, George Cassady's discussion, "Impact of Neonatal Intensive Care on the Quality of Life," may well be the most important chapter. There is no doubt that intensive care nurseries are saving lives, but what is the quality of those lives? Dr. Cassady's article contains impressive documentation that both the quantity and quality (as judged by neurological development) is improved by intensive perinatal care.

In their preface the authors state that the book "represents an effort to bring together those clinical concepts intrinsic to this specialty, dedicated to enhance the quality of the life of the unborn and ultimately the quality of the life of the newly born." In this reviewer's opinion, their efforts have succeeded.

LEMUEL MORRISON, M.D.

Review of Medical Pharmacology. 4th edition. 721 pages. Price, \$10.50. By F. H. Meyers, Ernest Jawetz, and Alan Goldfien. Los Altos, California: Lange Medical Publications, 1974.

The 4th edition of *Review of Medical Pharmacology* has not changed significantly from the 3rd edition. It

remains a "best buy" in paperback pharmacology publications and costs less than 1.5 cents per page. Consistent with the editors' intent, it is a biennial review of currently used drugs, with significant additions and deletions of drugs during this period and many helpful illustrations and tables. The outstanding chapters continue to be those in which a pathophysiologic basis for treatment is discussed—sections related to cancer chemotherapy, endocrinology, CNS drugs, antimicrobial agents, and a too brief treatise on drugs and the immune system.

The book has serious deficits which could be rectified without great effort. Each chapter, or related group of chapters, should have some pathophysiologic introduction and/or a therapeutic resume for uniformity. These need not be lengthy and, indeed, many contain such discussions. Needless de-

ficiencies continue to detract from this otherwise attractive publication. Only five pages are devoted to "respiratory drugs," which cover primarily antitussives and expectorants. On the other hand, 26 pages are devoted to "antiprotozoal drugs" and another 28 to "anthelmintic drugs" (drugs not approved for use in the United States, and agents considered to be investigational are discussed in at least seven pages). This comparison is made to stress the need for meaningful discussion of drug therapy of respiratory diseases.

The book is a first-class review for the medical student and practitioner, rather than for the research scientist or graduate student in pharmacology, but it is well worth its cost to anyone who desires a readable, up-to-date review in pharmacology.

JOHN S. KAUFMANN, M.D., Ph.D.

In Memoriam

ORVILLE EARL BELL, M.D.

Dr. Orville Earl Bell, a native of Snider, Oklahoma, born on September 1, 1905, a dedicated physician and valued friend to all who knew him, died on February 17, 1975, from injuries sustained in an automobile accident.

Graduating from the University of Oklahoma in 1935, he performed his internship at Norfolk General Hospital in Norfolk, Virginia. Then from 1936 to 1942, he practiced medicine in Winton, N. C. During the war from 1942 to 1945 he was sent by the Procurement and Assignment Committee of North Carolina to Richlands, N. C.

Since 1945, he has practiced in Rocky Mount where he was loved by many. He was affectionate and sensitive and loved his profession. He was familiar in all areas of the community, an active member of the First Baptist Church and also active in the Civitan Club, Masons and a member of the John Birch Society. He was a member of many medical organizations, some of which were the Southern Medical Society, the American Medical Society, the State Academy of Family Physicians and the Edgecombe-Nash Medical Society.

Surviving are his wife, Mrs. Esther Lanier Bell of the home; one daughter, Mrs. Sylvia Tilley of Rocky Mount; two sons, John Bell and Orville E. Bell, Jr. both of Raleigh; one sister, Mrs. D. J. Robinson of Ahoskie; one brother, Albert Bell of Durham, Ok-

lahoma; and one granddaughter, Miss Mary Alice Tilley of Rocky Mount.

Dr. Bell's loss will be greatly felt by his many friends and associates.

EDGECOMBE-NASH COUNTY MEDICAL SOCIETY

SHELDON ASA SAUNDERS, M.D.

On Monday, April 7, 1975, all that was mortal of our friend, Sheldon Asa Saunders, passed from this earth after a few months' illness. He died in the Roanoke-Chowan Hospital in Ahoskie, N. C., no more than 5 miles from his birthplace on a farm in Hertford County. He was born on October 7, 1886, and his life span of over 88 years encompassed and illustrated that basic love of God and His creation as well as the primal sense of dedication, community and commitment of a native Southern Gentleman.

After public schooling he attended Buies Creek Academy and the University of North Carolina at Chapel Hill, obtaining his M.D. in 1914 upon graduation from Jefferson Medical College. Following a year of internship at Norfolk Protestant (Norfolk General) Hospital he established a busy practice in Aulander, N. C., that flourished for a remarkable 60 years.

In this community to which he was devoted and which was devoted to him, he was the loving husband and devoted father. He sustained and participated in

many fundamental medical and civic organizations. Most importantly he sustained the citizenry of his community as a family physician *par excellence* who gave unstintingly of himself to his patients. Without guile, without rancor and without thought of recompense; in many instances his labors were requited with a look, a smile, a tear, a press of the hand but not the coin of this realm. "In my father, I observed his meekness; his constancy without wavering in those things, which after a due examination and deliberation, he had determined. How free from all vanity he

carried himself in matter of honor and dignity, his laboriousness and assiduity, his readiness to hear any man, that had aught to say tending to any common good; how generally and impartially he would give every man his due; his skill and knowledge, when rigor or extremity, or when remissness or moderation was in season; . . ."

Meditations of Marcus Aurelius I, 13

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*Committee and
Commission Appointments
1975-1976*

Committee and Commission Appointments

NOTE: The Committees listed herein have been authorized by President James E. Davis, M.D., and/or as required under the *Constitution and Bylaws*.

Particular note should be taken of the authorization of the HOUSE OF DELEGATES of a Commission form of organizational activity and that all Committees, excepting *COMMITTEE ON NOMINATIONS* and *MEDIATION COMMITTEE* are segregated under the respective Commission in which the function of the Committee logically rests. This will tend to eliminate overlapping and duplication in activity programs and result in coordination of the work of the Society in a manner to lessen the work of the delegates in the Annual Meeting of the HOUSE OF DELEGATES.

The President, Secretary and Executive Director of the Society are ex officio members of all Committees and, along with the Commission Chairman, should receive notice of meetings, agenda and minutes of committee meetings during the activity year.

(Superior figures (e.g. 21) indicate the component County Society from which the member emanates, as in the Membership list of the ROSTER.)

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A. Hewitt Rose, Jr., M.D., *Chairman*
3801 Computer Drive, Raleigh 27609

Committee Listing

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Wilson Clinic, Wilson 27893
2. **Personnel & Headquarters Operation, Com. on (I-2)** No. 39
A. Hewitt Rose, Jr., M.D., *Chairman*
3801 Computer Drive, Raleigh 27609
3. **Insurance, Com. on Professional (I-3)** No. 43
John C. Burwell, Jr., M.D., *Chairman*
1026 Professional Village, Greensboro 27401
4. **Retirement Savings Plan Committee (I-4)** No. 47
Robert W. Williams, M.D., *Chairman*
3208 Oleander Dr., Wilmington 28401
5. **ad hoc Committee to Study Professional Liability Insurance Problems I-5** No. 51
Ira Hardy, II, M.D., *Chairman*
1709 W. 6th St., Greenville 27834

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Albert Arthur Bechtoldt, Jr., M.D., *Chairman*
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3. Auxiliary, Committee Advisory to (II-3)

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4. Cancer, Committee on (II-4)

Rose Pully, M.D., *Chairman*
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5. Constitution & Bylaws, Com. on (II-5)

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7. Traffic Safety, Com. on (II-7)

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Wilson Clinic, Wilson 27893

8. ad hoc Committee on Relative Value Study (II-8)

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2. Audio-Visual Programs, Com. on (III-2)

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3. Awards, Committee on Scientific (III-3)

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4. **Credentials, Com. on (of House of Delegates) (III-4)** No. 15
John A. Payne, III, M.D., *Chairman*
Box 157, Sunbury 27979
5. **Exhibits, Committee on (III-5)** No. 20
Josephine E. Newell, M.D., *Chairman*
Box 68, Bailey 27807
6. **Medical Education, Committee on (III-6)** No. 31
Albert L. Chasson, M.D., *Chairman*
Rex Hospital, Raleigh 27603

IV. PROFESSIONAL SERVICE COMMISSION

Jack Hughes, M.D., *Chairman*
923 Broad Street, Durham 27705

1. **Blue Shield, Committee on (IV-1)** No. 8
R. Bertram Williams, Jr., M.D., *Chairman*
1414 Med. Ctr. Dr., Wilmington 28401
2. **Crippled Children's Program, Adv. Com. to (IV-2)** No. 16
Robert Underdal, M.D., *Chairman*
1900 S. Hawthorne Rd., Winston-Salem 27103
3. **Hospital & Professional Relations and Liaison to North Carolina Hospital Association, Com. on (IV-3)** No. 23
Charles L. Herring, M.D., *Chairman*
310 Glenwood Ave., Kinston 28501
4. **Industrial Commission, Com. to Work with N. C.** No. 24
Ernest B. Spangler, M.D., *Chairman*
Drawer X3, Greensboro 27402
5. **Insurance Industry Committee (IV-5)** No. 25
Charles H. Duckett, M.D., *Chairman*
Bowman Gray, Winston-Salem 27103
6. **Physical & Vocational Rehabilitation, Com. on (IV-6)** No. 41
Edwin H. Martinat, M.D., *Chairman*
3333 Silas Creek Parkway, Winston-Salem 27103

V. PUBLIC RELATIONS COMMISSION

Marshall S. Redding, M.D., *Chairman*
708 West Church Street, Elizabeth City 27909

1. **Association of Professions, Com. on (V-1)** No. 4
Thomas G. Thurston, M.D., *Chairman*
512 Mocksville Ave., Salisbury 28144
2. **Community Medical Care, Com. on (V-2)** No. 12
J. Kempton Jones, M.D., *Chairman*
1001 S. Hamilton Rd., Chapel Hill 27514
3. **Disaster and Emergency Medical Care, Com. on (V-3)** No. 18
George A. Watson, M.D., *Chairman*
4023 Bristol Rd., Durham 27707
4. **Eye Care & Eye Bank, Com. on (V-4)** No. 21
Ernest W. Larkin, Jr., M.D., *Chairman*
211 N. Market St., Washington 27889
5. **Legislation, Com. on (V-5)** No. 26
H. David Bruton, M.D., *Chairman*
Town Center, Southern Pines 28387
6. **Medical-Legal Committee (V-6)** No. 32
Julius Howell, M.D., *Chairman*
Bowman Gray, Winston-Salem 27103

7. **North Carolina Pharmaceutical Association, Com. Liaison to (V-7)** No. 40
Charles W. Byrd, M.D., *Chairman*
Box 708, Dunn 28334
8. **Public Relations, Committee on (V-8)** No. 44
John L. McCain, M.D., *Chairman*
Wilson Clinic, Wilson 27893
9. **ad hoc Committee to Study National Health Planning & Resources Act of 1974—PL 93-641 (V-9)** No. 52
Charles W. Styron, M.D., *Chairman*
615 St. Mary's St., Raleigh 27605

VI. PUBLIC SERVICE COMMISSION

Philip G. Nelson, M.D., *Chairman*
Medical Pavilion, Greenville 27834

1. **Child Health and Infectious Diseases, Com. on (VI-1)** No. 10
William L. London, M.D., *Chairman*
306 S. Gregson St., Durham 27701
2. **Chronic Illness, TB and Heart Disease, Com. on (VI-2)** No. 11
Dirk Verhoeff, M.D., *Chairman*
Huntersville Hosp., Huntersville 28078
3. **Drug Abuse, Committee on (VI-3)** No. 19
W. J. Kenneth Rockwell, M.D., *Chairman*
Duke Univ. Med. Ctr., Durham 27710
4. **Marriage Counselling & Family Life Education, Com. on (VI-4)** No. 27
John B. Reckless, M.D., *Chairman*
5504 Durham-Chapel Hill Blvd., Durham 27707
5. **Maternal Health, Committee on (VI-5)** No. 28
W. Joseph May, M.D., *Chairman*
300 S. Hawthorne Rd., Winston-Salem 27103
6. **Medical Aspects of Sports, Com. on (VI-6)** No. 30
Frank C. Wilson, M.D., *Chairman*
N. C. Mem. Hosp., Chapel Hill 27514
7. **Medicine and Religion, Com. on (VI-7)** No. 34
Jack W. Wilkerson, M.D., *Chairman*
1001 E. 4th St., Greenville 27834
8. **Mental Health, Com. on (VI-8)** No. 35
Philip G. Nelson, M.D., *Chairman*
Medical Pavilion, Greenville 27834
9. **Occupational & Environmental Health, Com. on (VI-9)** No. 38
Harold R. Imbus, M.D., *Chairman*
P. O. Box 21207, Greensboro 27420

VII. DEVELOPING GOVERNMENT HEALTH PROGRAMS COMMISSION

M. Frank Sohmer, Jr., M.D., *Chairman*
Professional Bldg., Winston-Salem 27103

1. **Comprehensive Health Service Planning, Com. on (VII-1)** No. 13
Robert C. Moffatt, M.D., *Chairman*
309 Doctors' Bldg., Asheville 28001
2. **Social Service Programs, Com. on (including Medicaid) (VII-2)** No. 48
J. Elliott Dixon, M.D., *Chairman*
215 E. 2nd St., Ayden 28513

Committees Not Assigned to a Commission
COUNCIL ON REVIEW & DEVELOPMENT

George G. Gilbert, M.D., *Chairman*
 1 Doctors Park, Asheville 28801

No. 17

MEDIATION COMMITTEE

Louis deS. Shaffner, M.D., *Chairman*
 Bowman Gray, Winston-Salem 27103
 Frank R. Reynolds, M.D., *Secretary*
 1613 Dock Street, Wilmington 28401

No. 29

NOMINATIONS, COMMITTEE ON

Oscar L. Sapp, III, M.D., *Chairman*
 UNC School of Medicine, Chapel Hill 27514

No. 36

1. Committee on Allied Health Professionals (6) (I Consultant) II-1

William B. McCutcheon, Jr., M.D.³² *Chairman*
 1830 Hillandale Road, Durham 27705
 J. Samuel Holbrook, M.D.⁴⁹
 Davis Hospital, Statesville 28677
 Frederick C. Hubbard, M.D.⁹⁷
 Box 39, N. Wilkesboro 28659
 Oliver Ray Hunt, Jr., M.D.⁶⁵
 1607 Doctors Circle, Wilmington 28401
 Wayne B. Venters, M.D.⁶⁷
 200 Doctors Dr., Suite J, Jacksonville 28540
 Donald K. Wallace, M.D.⁶³
 945 Sandavis Rd., Southern Pines 28387

Consultant:

Bryant D. Paris, Jr., Executive Secretary
 N. C. Board of Medical Examiners
 Suite 214, 222 N. Person St., Raleigh 27611

2. Committee on Anesthesia Study (8) II-2

Albert Arthur Bechtoldt, Jr., M.D.³² *Chairman*
 UNC School of Medicine, Chapel Hill 27514
 Heriberto Alfredo Ferrari, M.D.⁶⁰
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 Lewis J. Gaskin, M.D.⁹²
 Rex Hosp., Dept. Anes., Raleigh 27603
 C. T. Harris, M.D.⁶⁰
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 John R. Hoskins, III, M.D.¹¹
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 Albert R. Howard, M.D.²⁵
 P. O. Box 5025, New Bern 28560
 Bill Joe Swan, M.D.¹³
 776 Williamsburg Dr., Concord 28025
 H. Ryland Vest, Jr., M.D.⁷⁶
 529 Edgewood Rd., Asheboro 27203

3. Committee on Arrangements (14) (III-1)

E. Harvey Estes, Jr., M.D.³² *Chairman*
 Duke University Med. Ctr., Box 2914, Durham 27710
 *Lawrence M. Cutchin, M.D.³³ *Vice-Chairman*
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 H. David Bruton, M.D.⁶³
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 Chalmers R. Carr, M.D.⁶⁰ (Speaker)
 1822 Brunswick Ave., Charlotte 28207
 Kenneth E. Cosgrove, M.D.⁴⁵
 510 7th Ave., W., Hendersonville 28739
 John Glasson, M.D.³²
 306 S. Gregson St., Durham 27701
 Emery C. Miller, M.D.³⁴ (BG)
 Bowman Gray Sch. of Med., Winston-Salem 27103

Michael Pishko, M.D.⁶³ (GOLF)
 Pinehurst Surg. Clinic., Pinehurst 28374
 Frank R. Reynolds, M.D.⁶⁵
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 William H. Romm, M.D.⁷⁰ (TENNIS)
 Box 10, Moyock 27958
 Oscar L. Sapp, III, M.D.³² (UNC)
 UNC Sch. Med., Chapel Hill 27514
 Delford L. Stickel, M.D.³² (DUKE)
 Box 3917, Duke Hosp., Durham 27710
 Mrs. A. J. Crutchfield (Auxiliary)
 Quail Hollow Rd., Rt. 2, Clemmons 27102
 Henry J. Carr, Jr., M.D.⁸²
 603 Beamon St., Clinton 28328

*Coordinator for General Sessions Program

4. Committee on Association of Professions (3) V-1

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 512 Mocksville Ave., Salisbury 28144
 John S. Rhodes, M.D.⁹²
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 George G. Gilbert, M.D.¹¹
 1 Doctors Park, Asheville 28801

5. Committee on Audio Visual Programs (8) III-2

George Pat Henderson, Jr., M.D.⁶³ *Chairman*
 115 Highland Rd., Southern Pines 28387
 Paul McB. Abernethy, M.D.¹
 P. O. Box 2480, Burlington 27215
 Thornton R. Cleek, M.D.⁷⁶
 379 S. Cox Street, Asheboro 27203
 Jack C. Evans, M.D.²⁹
 244 Fairview Dr., Lexington 27292
 John C. Grier, Jr., M.D.⁶³
 Box 791, Pinehurst 28374
 Albert Stewart, Jr., M.D.²⁶
 114 Broadfoot Ave., Fayetteville 28305
 J. Benjamin Warren, M.D.²⁵
 Box 1465, New Bern 28560
 David Allen, M.D.⁶³
 Pinehurst Med. Clinic, Pinehurst 28374

6. Committee Advisory to Auxiliary (6) (I Consultant) II-3

Gloria F. Graham, M.D.⁹⁸ *Chairman*
 702 Broad St., Wilson 27893
 Robert J. Andrews, M.D.⁶⁵
 5221 Wrightsville Ave., Wilmington 28401
 Bruce B. Blackmon, M.D.⁴³
 P. O. Box 8, Buies Creek 27506
 A. J. Crutchfield, M.D.³⁴
 93 Professional Bldg., Winston-Salem 27103
 Charles L. Herring, M.D.⁵⁴
 310 Glenwood Ave., Kinston 28501
 Philip E. Russell, M.D.¹¹
 204 Doctors Bldg., Asheville 28801

Consultant:

Mrs. William Corpening (AMA-ERF Auxiliary Chairman)
 Box 200, Granite Falls 28630

7. Committee on Scientific Awards (8) (3-yr. terms) III-3

David S. Citron, M.D.⁶⁰ (1978), *Chairman*
 Box 2554, Charlotte Mem. Hosp., Charlotte 28201
 John A. Brabson, M.D.⁶⁰ (1976)
 225 Hawthorne Lane, Charlotte 28204
 Frank M. Mauney, Jr., M.D.¹¹ (1976)
 257 McDowell Street, Asheville 28801

Emery C. Miller, M.D.⁴¹ (1977)
Bowman Gray, Winston-Salem 27103
Oscar L. Sapp, III, M.D.³² (1978)
UNC Sch. of Medicine, Chapel Hill 27514
Robert Smith, M.D.³² (1977)
UNC Sch. Med., Chapel Hill 27514
Roger E. Smith, M.D.⁶⁰ (1978)
1351 Durwood Dr., Charlotte 28204
James Tidler, M.D.⁶⁵ (1977)
1919 S. 16th St., Wilmington 28401

8. Committee on Blue Shield (32) (9 Consultants) IV-1

R. Bertram Williams, Jr., M.D.⁶⁵ (GS) (III) (1977) *Chairman*
1414 Med. Ctr. Dr., Wilmington 28401
Angus M. McBryde, Jr., M.D.⁶⁰ (ORS) (VII) (1977),
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1822 Brunswick Ave., Charlotte 28207
Freeman Albert Berne, M.D.⁷⁸ (R) (V) (1978)
102 W. 27th St., Lumberton 28358
D. Clark Bright, M.D.³² (AN) (VI) (1978)
Box 2751, Burlington 27215
Edwin L. Bryan, M.D.⁴¹ (IM) (VIII) (1978)
200 E. Northwood St., Greensboro 27401
James E. Collins, M.D.⁴¹ (P) (VIII) (1978)
1122 Virginia St., Greensboro 27403
William F. Crutchley, Jr., M.D.⁷⁰ (GS) (I) (1978)
1134 N. Road St., Elizabeth City 27909
Arthur E. Davis, Jr., M.D.⁹² (PTH) (VI) (1976)
1209 Cowper Dr., Raleigh 27608
Melvin F. Eyerman, M.D.⁵⁵ (PH) (VII) (1977)
Box 636, Lincolnton 28092
William W. Farley, M.D.⁹² (Pd) (VI) (1976)
1300 St. Mary's St., Suite 402, Raleigh 27605
John W. Foust, M.D.⁶⁰ (OTO) (VII) (1977)
3535 Randolph Rd., Charlotte 28211
Joe Thomas Fox, Jr., M.D.⁶⁰ (P) (VII) (1977)
1900 Randolph Rd., Charlotte 28207
Robert M. Gay, M.D.⁴¹ (PTH) (VIII) (1977)
1200 N. Elm St., Greensboro 27405
Gloria F. Graham, M.D.⁹⁸ (D) (IV) (1977)
702 Broad St., Wilson 27893
Charles L. Herring, M.D.⁵⁴ (I) (II) (1976)
310 Glenwood Ave., Kinston 28501
Victor G. Herring, III, M.D.³³ (Pd) (IV) (1977)
Tarboro Clinic, Tarboro 27886
David L. Kelly, Jr., M.D.³⁴ (NS) (VIII) (1977)
Bowman Gray, Winston-Salem 27103
John T. Langley, M.D.⁵⁴ (ORS) (II) (1976)
Kinston Clinic, Kinston 28501
H. Raymond Madry, Jr., M.D.⁹² (DR) (VI) (1976)
3821 Merton Dr., Raleigh 27609
John R. Marchese, M.D.⁹⁵ (ObG) (IX) (1978)
100 Kimberly Dr., Boone 28607
John H. Monroe, M.D.³⁴ (ObG) (VIII) (1976)
Ste. 718, Forsyth Med. Park, Winston-Salem 27103
Frank C. Morrison, M.D.⁴⁴ (GP) (X) (1976)
Box 1192, Canton 28716
H. Maxwell Morrison, Jr., M.D.⁶³ (Oph) (V) (1978)
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Sarah A. T. Morrow, M.D.⁴¹ (PH) (VIII) (1976)
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Robert D. O'Conner, M.D.¹⁸ (OTO) (IX) (1976)
P. O. Drawer 2484, Fairgrove Church Rd., Hickory 28601
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3208 Oleander Dr., Wilmington 28401
Irvin P. Plaisance, Jr., M.D.¹¹ (U) (X) (1977)
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Wilbur Thadeus Shearin, Jr., M.D.⁶⁵ (U) (III) (1978)
1905 Glen Meade Rd., Wilmington 28401
George T. Thornhill, M.D.⁹² (Oph) (VI) (1977)
720 W. Jones St., Raleigh 27603
Robert L. Timmons, M.D.⁷⁴ (NS) (II) (1976)
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Marshall G. Morris, Jr., M.D.⁴¹ (S)
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Francis Robicsek, M.D.⁶⁰ (S-TS-CV)
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John T. Sessions, Jr., M.D.³² (GE)
UNC Sch. Med., Chapel Hill 27514
John L. Wooten, M.D.⁷⁴ (ORS)
6 Medical Pavilion, Greenville 28734

9. Committee on Cancer (11) (Legal-1 ea. Congressional District) (3 Consultants) II-4

Rose Pully, M.D.⁵⁴ (1st), *Chairman*
1007½ N. College St., Kinston 28501
Joshua F. B. Camblos, M.D.¹¹ (11th)
108 Doctors Bldg., Asheville 28801
Rowell C. Cloninger, M.D.²³ (10th)
Shelby Med. Center, Shelby 28150
Charles Pell Lewis, Jr., M.D.⁷⁹ (6th)
P. O. Box 329, Reidsville 27320
Eugene B. Linton, M.D.³⁴ (5th)
2927 Lyndhurst Ave., Winston-Salem 27103
James A. Maher, M.D.⁹⁶ (3rd)
Wayne Co. Hosp., Goldsboro 27530
Richard W. Martin, M.D.⁴⁹ (9th)
435 E. Statesville Ave., Mooresville 28115
Walter J. Loehr, M.D.³² (4th)
1200 Broad St., Durham 27705
Lewis S. Thorp, M.D.³³ (2nd)
100 Med. Arts Mall, Rocky Mount 27801
John Morris Wallace, M.D.⁸⁴ (8th)
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Consultants:

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Warren H. Cole, M.D.¹¹
8 W. Kensington Rd., Asheville 28804

10. Committee on Child Health & Infectious Diseases (14) VI-1

William L. London, M.D.³² *Chairman*
306 S. Gregson St., Durham 27701

Linny Marshall Baker, M.D.¹³
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 UNC Sch. Med., Chapel Hill 27514
 E. Stephen Edwards, M.D.⁹²
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 Tarboro Clinic, Tarboro 27886
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 Richard S. Kelly, Jr., M.D.²⁶
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 John F. Lynch, Jr., M.D.⁴¹
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 John W. Nance, M.D.⁸²
 403 Fairview St., Clinton 28328
 Oliver F. Roddey, Jr., M.D.⁶⁰
 1928 Randolph Rd., Charlotte 28207
 David T. Tayloe, M.D.⁷
 608 E. 12th St., Washington 27889

11. Committee on Chronic Illness, Including TB & Heart Disease (13) VI-2

Dirk Verhoeff, M.D.⁶⁰ *Chairman*
 Huntersville Hosp., Huntersville 28078
 J. Dewey Dorsett, Jr., M.D.⁶⁰
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 O. David Garvin, M.D.³²
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 Isa C. Grant, M.D.⁹²
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 Thomas F. Kelley, M.D.⁸⁴
 320 Yadkin St., Albemarle 28001
 Thomas D. Long, M.D.⁷³
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 Michael A. McCall, M.D.⁵⁹
 442 Fleming Ave., Marion 28752
 Hubert G. Pierce, M.D.⁵⁴
 313 Airport Rd., Kinston 28501
 Wilbur James Steininger, M.D.⁴⁷
 McCain Hospital, McCain 28361
 Abram L. Van Horn, M.D.³²
 UNC, Dept. Hosp. Adm., Chapel Hill 27514
 George A. Watson, M.D.³²
 4023 Bristol Rd., Durham 27707

12. Committee on Community Medical Care (17) V-2

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 James A. Bryan, II, M.D.³²
 N. C. Mem. Hosp., Chapel Hill 27514
 Edward L. Boyette, M.D.³²
 Chiquapin 28521
 F. Murray Carroll, M.D.²⁴
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 W. T. Grimsley, M.D.⁴¹
 P. O. Box 8, Summerfield 27358

Donald M. Hayes, M.D.³⁴
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 Julian F. Keith, Jr., M.D.³⁴
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 Elam S. Kurtz, M.D.⁵
 Lansing 28643
 C. Rex LaGrange, M.D.⁹
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 George M. Leiby, M.D.⁸⁴
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 Ronald H. Levine, M.D.⁹²
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 J. J. Pence, Jr., M.D.⁶⁵
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 Emery L. Rann, M.D.⁶⁰
 1001 Beatties Ford Rd., Charlotte 28216
 Cecil D. Rhodes, Jr., M.D.⁹⁸
 Carolina General Clinic, Wilson 27893

13. Committee on Comprehensive Health Service Planning (18) VII-1

Robert C. Moffatt, M.D.¹¹ *Chairman*
 309 Doctors Bldg., Asheville 28801
 Hugh A. Matthews, M.D.⁴⁴ (Region A-State of Franklin)
 Western Carolina Univ., Cullowhee 28723
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 John A. McLeod, Jr., M.D.¹¹ (Region B-Central Highlands)
 Mem. Mission Hosp., Asheville 28801
 James T. McRae, M.D.⁶¹ (Region D-WAMY)
 Bowman Gray, Winston-Salem 27103
 John C. Reece, M.D.¹² (Region E-Eastern Appalachia)
 Hwy 18-S. Grace Hospital, Morganton 28655
 Henry H. Nicholson, Jr., M.D.⁶⁰ (Region F)
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 O. Norris Smith, M.D.⁴¹ (Region G-Piedmont-Triad)
 1019 Prof. Village, Greensboro 27401
 Alfred G. Siegel, M.D.⁶³ (Region H-South Central)
 Moore Co. Hlth Dept., Carthage 28327
 Lyndon K. Jordan, M.D.⁵¹ (Region J)
 P. O. Box 760, Smithfield 27577
 James P. Green, M.D.⁹¹ (Region K)
 176 Beckford Dr., Henderson 27536
 Bruce B. Blackmon, M.D.⁴³ (Region M)
 P. O. Box 8, Buies Creek 27506
 William H. Romm, M.D.⁷⁰ (Region R)
 Box 10, Moyock 27958
 Harry H. Summerlin, Sr., M.D.⁸³ (Region N)
 Box 506, Laurinburg 28352
 Lawrence M. Cutchin, M.D.³³ (Region L)
 P. O. Box 40, Tarboro 27886
 Zack J. Waters, Jr., M.D.²⁵ (Region P)
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 Ralph B. Moore, Jr., M.D.⁶⁵
 3208 Oleander Dr., Wilmington 28401
 Lynwood E. Williams, M.D.⁵⁴ (Region Q)
 400 Glenwood Ave., Kinston 28501

14. Committee on Constitution & Bylaws (5) II-5

Louis deS. Shaffner, M.D.³⁴ *Chairman*
 Bowman Gray, Winston-Salem 27103

Chalmers R. Carr, M.D.⁶⁰
 1822 Brunswick Ave., Charlotte 28207
 Henry J. Carr, Jr., M.D.⁸²
 603 Beamon St., Clinton 28328
 P. G. Fox, Jr., M.D.⁹²
 1110 Wake Forest Rd., Raleigh 27604
 John H. Hall, M.D.⁴¹
 1100 Olive St., Greensboro 27401

15. Committee on Credentials (of Delegates to House of Delegates) (3) III-4

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 Box 157, Sunbury 27979
 L. Harvey Robertson, Sr., M.D.⁸⁰
 Box 4519, Salisbury 28144
 Louis R. Wilkerson, M.D.⁹²
 100 S. Boylan Ave., Raleigh 27603

16. Advisory Committee to the Crippled Children's Program (8) IV-2

Robert Underdal, M.D.³⁴ *Chairman*
 1900 S. Hawthorne Rd., Winston-Salem 27103
 Richard H. Ames, M.D.⁴¹
 1018 Prof. Village, Greensboro 27401
 John I. Brooks, Jr., M.D.³⁴
 Tarboro Clinic, Tarboro 27886
 Ralph W. Coonrad, M.D.³²
 1828 Hillandale Rd., Durham 27705
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 William W. Morgan, Jr., M.D.¹¹
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 James C. Parke, Jr., M.D.⁶⁰
 Charlotte Mem. Hosp., Box 2554, Charlotte 28201
 William R. Pitser, M.D.³⁴
 621 Nokomis Ct., Winston-Salem 27106

17. Council on Review & Development (10) (4 Ex Officio with Vote) (1 Non-voting)

George G. Gilbert, M.D.¹¹ *Chairman*
 1 Doctors Park, Asheville 28801
 John Glasson, M.D.³² *Vice-Chairman*
 306 S. Gregson St., Durham 27701
 Charles W. Styron, M.D.⁹²
 615 St. Mary's St., Raleigh 27605
 Louis deS. Shaffner, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Edgar T. Beddingfield, Jr., M.D.⁹⁸
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Ex Officio with Vote:

James E. Davis, M.D.³² (President)
 1200 Broad St., Durham 27705
 Jesse Caldwell, Jr., M.D.³⁶ (President-Elect)
 114 W. 3rd Ave., Gastonia
 Frank R. Reynolds, M.D.⁶⁰ (Past President)
 1613 Dock St., Wilmington 28401

E. Harvey Estes, Jr., M.D.³² (Secretary)
 Duke Univ. Med. Ctr., Durham 27710

Ex Officio Non-Voting:

William N. Hilliard, (Executive Director)
 222 N. Person St., Raleigh 27611

18. Committee on Disaster & Emergency Medical Care (12) V-3

George A. Watson, M.D.³² *Chairman*
 4023 Bristol Rd., Durham 27707
 Frank W. Clippinger, M.D.³²
 Box 2919, Duke Med. Ctr., Durham 27710
 Sara J. Dent, M.D.³²
 Box 3094, Duke Hosp., Durham 27710
 George Johnson, Jr., M.D.³²
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 Frank H. Longino, M.D.⁷⁴
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 R. Tempest Lowry, M.D.⁹²
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 Jesse Meredith, M.D.³⁴
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 Robert E. Price, Jr., M.D.³²
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 George T. Wolff, M.D.⁴¹
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19. Committee on Drug Abuse (9) (4 Consultants) VI-3

W. J. Kenneth Rockwell, M.D.³² *Chairman*
 Duke Univ. Med. Ctr., Durham 27710
 Benjamin E. Britt, M.D.⁹²
 3725 National Dr., Raleigh 27612
 R. Jackson Blackley, M.D.⁹²
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 Jonnie H. McLeod, M.D.⁶⁰
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 Richard L. Spencer, M.D.³⁴
 560 Forsyth Med. Ctr., Winston-Salem 27101
 Robert W. Whitener, M.D.⁴¹
 1024 Prof. Village, Greensboro 27401
 Robert E. Williford, M.D.⁷⁶
 208 Foust St., Asheboro 27203

Consultants:

Mr. W. J. Smith, Ex. Secy., N. C. Pharmaceutical Assn.
 Drawer 151, Chapel Hill 27514
 Mr. F. E. (Roy) Epps, Director, N. C. Drug Authority
 222 N. Person St., Raleigh 27601
 Mr. Charles J. Dunn, Jr., Director, SBI
 421 N. Blount St., Raleigh 27611
 Col. E. W. Jones, Commander, Highway Patrol
 N. C. Divn. Motor Vehicles Bldg., Raleigh 27610

20. Committee on Exhibits (6) III-5

Josephine E. Newell, M.D.⁹² *Chairman*
 Box 68, Bailey 27807

Robert G. Brame, M.D.³²
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 Gloria F. Graham, M.D.⁹⁸
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 Rose Pully, M.D.⁵⁴
 1007½ N. College St., Kinston 28501
 George G. Gilbert, M.D.¹¹
 1 Doctors Park, Asheville 28801
 Josephine T. Melchior, M.D.²⁶
 1661 Owen Dr., Fayetteville 28304

21. Committee on Eye Care & Eye Bank (15) V-4

Ernest W. Larkin, Jr., M.D.⁷ *Chairman*
 211 N. Market St., Washington 27889
 Paul M. Abernethy, M.D.¹
 P. O. Box 2480, Burlington 27215
 Lloyd W. Bailey, M.D.³³
 109 Foy Dr., Rocky Mount 27801
 Arthur C. Chandler, Jr., M.D.³²
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 Daniel S. Currie, Jr., M.D.²⁶
 111 Bradford Ave., Fayetteville 28301
 Alan Davidson, M.D.²⁵
 Box 250, New Bern 28560
 Edward K. Isbey, M.D.¹¹
 3-C Doctors' Park, Asheville 28801
 Albin W. Johnson, M.D.⁹²
 1300 St. Mary's St., Raleigh 27605
 Thomas C. Kerns, Jr., M.D.³²
 1110 W. Main St., Durham 27701
 Norman M. Sawyer, M.D.⁶⁰
 2024 Randolph Rd., Charlotte 28207
 David B. Sloan, Jr., M.D.⁶⁵
 1915 Glen Meade Road, Wilmington 28401
 J. David Stratton, M.D.⁶⁰
 1012 Kings Dr., Rm. 402, Charlotte 28283
 Shahane R. Taylor, Jr., M.D.⁴¹
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 Charles W. Tillett, Jr., M.D.⁶⁰
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 Wayne Woodard, M.D.¹¹
 607 Flatiron Bldg., Asheville 28801

22. Committee on Finance (3) (7 Consultants)

T. Tilghman Herring, M.D.⁹⁸ *Chairman*
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 J. Henry Cutchin, Jr., M.D.¹⁸
 Sherrills Ford 28673
 Thomas B. Dameron, Jr., M.D.⁹²
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Consultants:

I—A. Hewitt Rose, Jr., M.D.⁹²
 3801 Computer Dr., Raleigh 27609
 II—Marvin N. Lymberis, M.D.⁶⁰
 1600 E. 3rd St., Charlotte 28204
 III—Josephine E. Newell, M.D.⁹⁸
 Box 68, Bailey 27807
 IV—Jack Hughes, M.D.³²
 923 Broad St., Durham 27705
 V—Marshall S. Redding, M.D.⁷⁰
 708 West Church St., Elizabeth City 27909
 VI—Philip G. Nelson, M.D.⁷⁴
 9 Medical Pavilion, Greenville 27834
 VII—M. Frank Sohmer, Jr., M.D.³⁴
 Prof. Bldg., Winston-Salem 27103

23. Committee on Hospital & Professional Relations & Liaison to North Carolina Hospital Association (10) IV-3

Charles L. Herring, M.D.³⁴ (2nd) *Chairman*
 310 Glenwood Ave., Kinston 28501
 Lawrence M. Cutchin, M.D.³³ (4th)
 P. O. Box 40, Tarboro 27886
 Archie Y. Eagles, M.D.⁴⁶ (1st)
 Medical Arts Ctr., Ahoskie 27910
 Charles O. Van Gorder, M.D.²⁰ (10th)
 Valley River Clinic, Andrews 28901
 Edward Stephens Martin, M.D.⁶⁰ (7th)
 1928 Randolph Rd., Charlotte 28207
 Claude A. McNeil, Jr., M.D.⁸⁶ (8th)
 180-B Parkwood Dr., Elkin 28621
 J. Olin Perritt, Jr., M.D.⁶⁵ (3rd)
 2212 Delaney Rd., Wilmington 28401
 Kenneth A. Podger, M.D.³² (6th)
 1830 Hillandale Rd., Durham 27705
 Charles P. Scheil, M.D.¹⁴ (9th)
 Box 431, Blackwelder Clinic, Lenoir 28645
 E. Wilson Staub, M.D.⁶³ (5th)
 Pinehurst Surgical Clinic, Pinehurst 28374

24. Committee to Work with North Carolina Industrial Commission (15) IV-4

Ernest B. Spangler, M.D.⁴¹ *Chairman*
 Drawer X3, Greensboro 27402
 Leroy Allen, M.D.⁹²
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 William T. Berkeley, Jr., M.D.⁶⁰
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 Thomas E. Castelloe, M.D.⁹²
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 George M. Cooper, M.D.⁹²
 201 Bryan Bldg., Raleigh 27605
 Benjamin W. Goodman, M.D.¹⁸
 24 2nd Ave., NE, Hickory 28601
 Robert L. Means, M.D.³⁴
 2240 Cloverdale Ave., Winston-Salem 27103
 Carl J. Hiller, M.D.²⁵
 P. O. Drawer 1694, New Bern 28560
 Julius Howell, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Thomas C. Kerns, Jr., M.D.³²
 1110 W. Main St., Durham 27701
 Jack Powell, M.D.¹¹
 190 W. Doctors Bldg., Asheville 28801
 Richard C. Proctor, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
 Robert E. Miller, M.D.⁶⁰
 1822 Brunswick Ave., Charlotte 28207
 Charles L. Nance, Jr., M.D.⁶⁵
 315 N. 17th St., Wilmington 28401
 Samuel A. Sue, Jr., M.D.⁴¹
 1311 N. Elm St., Greensboro 27401

25. Insurance Industry Committee (28) IV-5

Charles H. Duckett, M.D.⁴⁴ (GP) *Chairman*
 Bowman Gray, Winston-Salem 27103
 Marcus L. Aderholdt, M.D.⁴¹ (Pd) *Vice-Chairman*
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 Richard M. Aderholdt, M.D.³⁴ (P)
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 James D. Anderson, M.D.⁶⁰ (ObG)
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A. J. Crutchfield, M.D.³⁴
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Bruce J. Franz, M.D.¹¹ (S)
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Norman H. Garrett, Jr., M.D.⁴¹ (I)
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Odell C. Kimbrell, Jr., M.D.⁹² (End)
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David S. Johnston, M.D.⁶⁰ (ORS)
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Bowman Gray, Winston-Salem 27103

William R. Pitser, M.D.³⁴ (OTO)
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180C Parkway Dr., Elkin 28621

Lawrence K. Thompson, III, M.D.³² (PS)
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Richard E. Weiss, M.D.¹¹ (NS)
215 Doctors Park, Asheville 28801

26. Committee on Legislation (3 Plus President and Secretary)
(16 Consultants) V-5

H. David Bruton, M.D.⁶³ *Chairman*
Town Center, Southern Pines 28387

John H. Hall, M.D.⁴¹ *Vice-Chairman*
1100 Olive St., Greensboro 27401

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James E. Davis, M.D.³² (President)
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E. Harvey Estes, Jr., M.D.³² (Secretary)
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Chowan Med. Ctr., Edenton 27932

Kenneth E. Cosgrove, M.D.⁴⁵
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Archie T. Johnson, Jr., M.D.⁹²
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C. Clement Lucas, Jr., M.D.²¹
Chowan Med. Ctr., Edenton 27932

Charles P. Nicholson, Jr., M.D.¹⁶
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J. David Stratton, M.D.⁶⁰
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James F. Toole, M.D.³⁴
Bowman Gray, Winston-Salem 27103

John L. Abernethy, (Student)³²
Duke Hosp., Box 2701, Durham 27710

27. Committee on Marriage Counseling & Family Life Education
(13) VI-4

John B. Reckless, M.D.³² *Chairman*
The John Reckless Clinic, 5504 Durham-Chapel Hill Blvd., Durham 27707

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Takey Crist, M.D.⁶⁷
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Rachel D. Davis, M.D.³⁴
111 E. Gordon St., Kinston 28501

Eleanor B. Easley, M.D.³²
1821 Green St., Durham 27705

W. Davis Fort, M.D.⁸⁴
100 N. Fifth St., Albemarle 28001

Jerry Hulka, M.D.³²
UNC, Dept. of ObG, Chapel Hill 27514

Eugene B. Linton, M.D.³⁴
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Hans Lowenbach, M.D.³²
Rt. 3, Box 273, Durham 27707

Luther M. Talbert, M.D.³²
N. C. Mem. Hosp., Chapel Hill 27514

28. Committee on Maternal Health (14) VI-5 (6 yr. Terms)

W. Joseph May, M.D.³⁴ (8th) (1976) *Chairman* and *Secretary*
300 S. Hawthorne Rd., Winston-Salem 27103

Stephen G. Anderson, M.D.³⁴ (1977)
2927 Lyndhurst Ave., Winston-Salem 27103

Clifford C. Byrum, M.D.⁹² (6th) (1979)
3803 Computer Dr., Raleigh 27609

Jesse Caldwell, Jr., M.D.³⁶ (7th) (1979)
114 W. 3rd Ave., Gastonia 28052

A. Barry Campbell, M.D.¹¹ (10th) (1981)
 Doctor's Bldg., NW Annex, Asheville 28801
 Arthur C. Christakos, M.D.³² (Duke) (1978)
 Duke Hosp., Box 3274, Durham 27710
 William E. Easterling, Jr., M.D.³² (UNC) (1981)
 UNC School of Med., Chapel Hill 27514
 H. Fleming Fuller, M.D.⁵⁴ (2nd) (1981)
 Kinston Clinic, Box 268, Kinston 28501
 Edgar C. Garber, Jr., M.D.²⁶ (5th) (1977)
 1641 Owen Dr., Fayetteville 28304
 William A. Hoggard, Jr., M.D.⁷⁹ (1st) (1977)
 1142 N. Road St., Elizabeth City 27909
 Ann H. Huizenga, M.D.⁹² (1978)
 Div. of Health Services, Box 2091, Raleigh 27602
 John A. Kirkland, M.D.⁹⁸ (4th) (1976)
 Wilson Clinic, Wilson 27893
 John W. Nance, M.D.⁸² (3rd) (1978)
 403 Fairview St., Clinton 28328
 Robert L. Rogers, Jr., M.D.¹⁴ (9th) (1976)
 328 Mulberry St., NW, Suite 2, Lenoir 28645

29. Mediation Committee (5) (Five Immediate Past Presidents)

Louis deS. Shaffner, M.D.³⁴, *Chairman*
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 Frank R. Reynolds, M.D.⁶⁵ *Secretary*
 1613 Dock St., Wilmington 28401
 Charles W. Styron, M.D.⁹²
 615 St. Mary's St., Raleigh 27605
 John Glasson, M.D.³²
 306 S. Gregson St., Durham 27701
 George G. Gilbert, M.D.¹¹
 1 Doctors Park, Asheville 28801

30. Committee on Medical Aspects of Sports (17) (2 Consultants) VI-6

Frank C. Wilson, M.D.³² *Chairman*
 N. C. Mem. Hosp., Chapel Hill 27514
 Frank H. Bassett, III, M.D.³²
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 James F. Bowman, M.D.⁷⁴
 6 Medical Pavilion, Greenville 27834
 Basil M. Boyd, Jr., M.D.⁶⁰
 1822 Brunswick Ave., Charlotte 28207
 Paul L. Burroughs, Jr., M.D.⁹²
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 30 Doctors' Park, Boone 28607
 Carl J. Hiller, M.D.²⁵
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Consultants:

Al Proctor, Ph.D., N. C. Dept. Public Instruction
 Sports Medicine Div., Education Bldg., Raleigh 27605
 Raymond K. Rhodes, Director of Athletics, State
 Dept. of Public Instruction, Raleigh 27605

31. Committee on Medical Education (25) (3 Consultants) II-6

Albert L. Chasson, M.D.⁹² (PTH) *Chairman*
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 John D. Bridgers, Sr., M.D.⁴¹ (PD)
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 Donal Leo Dunphy, M.D.³² (PD)
 UNC Dept. of Pediatrics, Chapel Hill 27514
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Consultants:

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 Medical Science Teaching Labs, Chapel Hill 27514
 Mr. George Lynch, Audio-Visual Dept.
 Bowman Gray, Winston-Salem 27103
 Ron W. Davis, Ed.D
 Box 8248, Durham 27704

32. Medical-Legal Committee (8) V-6

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 Watts Hosp., Durham 27705
 Arned Lee Hinshaw, M.D.³²
 306 S. Gregson St., Durham 27705
 Henry D. Severn, M.D.¹¹
 283 Biltmore Ave., Asheville 28801

33. Committee Advisory to Medical Students (7) II-7

William P. J. Peete, M.D.³² *Chairman*
 Duke Univ. Med. Ctr., Durham 27710
 James A. Bryan, II, M.D.³²
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 Mr. Fred Sanfilippo (Duke)
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 Adrian E. Long (UNC)
 1 Clark Rd., Chapel Hill 27514
 Mr. Edward Warren (BG)
 2402 Fairway Dr., Winston-Salem 27103

34. Committee on Medicine & Religion (10) (4 Consultants) VI-7

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Consultants:

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 Central United Methodist Church
 27 Church St., Asheville 28801
 Rev. T. Max Linnens
 Box 161, Boiling Springs 28017
 Rev. Samuel Wiley
 Box 6637, College Sta., Durham 27708
 Father Thomas J. O'Donnel
 Box 859, Clinton 28328

35. Committee on Mental Health (30) VI-8

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 R. Jackson Blackley, M.D.⁹²
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 Thomas E. Curtis, M.D.³²
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 Robert W. Gibson, Jr., M.D.¹²
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 Alanson Hinman, M.D.³⁴
 Bowman Gray, Winston-Salem 27103
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 Hervy Basil Kornegay, Sr., M.D.⁹⁶
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Medical Journal

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Students, Medical.....

The President's Address

Unity and Participation for Better Medicine

James E. Davis, M.D.

IT is with a deep sense of humility and gratitude that I express my appreciation to the Society for the privilege of serving as your president and for the opportunity of addressing you, today for the first time, in this capacity. The North Carolina Medical Society is a long-established and esteemed society whose heritage long antedates our formal organization 126 years ago.

The practice of medicine in America began here in North Carolina. The first physician to live and practice in the New World—Thomas Hariot—settled on Roanoke Island in August, 1585, with the Sir Walter Raleigh colony. Hariot was specially trained in medicine not only to care for the colonists but to observe and record the manners and customs of the natives and to describe all available medicinal herbs. The colony returned to England the following year having lost only four of the 108 colonists. Hariot proudly recorded that these four were "feeble, weak, and sickly on leaving home" and that none had died of any peculiarity of the climate or from the strange environment to which they had been exposed—sentiments reminiscent of the recent concern for our returning astronauts from a foreign world of a different kind.

A hundred years would pass before the next physician appeared in North Carolina, but thereafter the number grew steadily and by the time of the Revolution an estimated 400 physicians had come to live in the state. In 1799, sixteen years after the end of the Revolution, the first North Carolina Medical Society was founded, but it survived only six years. In 1849, two years after the formation of the American Medical Association, our present society began its long and uninterrupted history. Where do we find ourselves 126 years later?

Today, medicine is in turmoil. It is being ques-

tioned, challenged and criticized as never before. It is now experiencing its period of greatest change.

Yesterday, President Reynolds properly and accurately alerted you to the alarming provisions of the National Health Planning and Resources Development Act of 1974. This law, enacted over vigorous medical opposition, for the first time in the history of federal health legislation sets as a priority of government the regulation of the quality and the costs of health care. This law literally federalizes medicine into a public utility under the control of the Secretary of Health, Education and Welfare and administered by consumer-dominated groups at the federal, state and local levels. The power of these groups and that of the secretary to regulate all aspects of medicine—including your practice and mine—appears to be unlimited. Unfortunately, too few physicians realize that the framework of government-controlled medicine, upon which the details of National Health Insurance will later be placed, has already become the law of the land.

What can we do about it now? We can begin to see that the very best possible medical representation participates in the implementation of this law. The governor has now recommended to the Secretary of HEW that six Health Service Areas be established in North Carolina and the boundaries of these are now known for the first time. Dr. Archie Johnson, working with Secretary Flaherty, is selecting physicians to work in the Health System Agency in each of these areas. Dr. Johnson solicits your recommendations for these positions and also your suggestions how the state agency should be established. Physicians can still influence the implementation of this program in North Carolina if we act at once.

Also in the 93rd Congress of last fall, a health manpower bill was passed by both houses, only to die in conference committee by adjournment. A similar bill has been introduced this year and an early vote is expected. Though there are many beneficial provi-

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Reprint requests to Dr. Davis, 1200 Broad Street, Durham, North Carolina 27705.

sions in this bill such as the continuation of loans and grants to medical schools, loans and scholarships to medical students, and assistance for the training of primary physicians and allied health personnel, there are certain new concepts in this bill which raise strong objection. Among these are federal control of the number and location of all medical residency training programs, and a requirement that all medical students repay the government, by a period of indentured service following graduation, for the federal aid which their medical school has received.

There is no demonstrated need for the federal government to assume control of graduate medical education. Recent evolutionary changes show that there has been a 69 percent increase in the number of graduates entering residency-training programs in the "primary care" specialties and that nearly 50 percent of medical graduates in 1973 entered primary care specialty programs. These beneficial changes, which accomplish the stated purposes of this bill, have taken place without federal regulatory controls.

To require medical students, as a personal obligation, to repay to the federal government those amounts which the government has given to the schools is unreasonable, unprecedented and discriminatory. North Carolina, with three superior medical schools and long noted for its excellence in graduate medical training, will be severely and adversely affected by this legislation. What can we do about this pending legislation? I am asking our Committee on Legislation to carefully monitor the progress of this bill and to direct our campaign to inform our congressional delegation of our feelings in this matter at the most appropriate time.

What is the status of National Health Insurance? As you know, many national health insurance bills have been introduced in the Congress and are under study. Just last week the AMA's new proposal—HR6222—The Comprehensive Health Care Insurance Act was introduced into the House of Representatives. Although we have lived under the specter of the passage of National Health Insurance "next year" for some time now, most congressional observers feel that the 94th Congress wants to be and probably will be known as the "Health Insurance Congress." The current economic situation likely precludes passage of significant health legislation this year. But it is felt that with improved conditions next year passage prior to the elections of 1976—probably of a composite bill—is a likelihood. Hopefully the ultimate bill will incorporate the basic features of: (A) Comprehensive coverage and benefits; (B) Building on our present structure of group health insurance; (C) Assuring federal financial assistance on the basis of need; (D) Free choice of care by both the recipient and provider and (E) Cost controls which are positive in nature.

Professional liability insurance continues to be a major problem—not only here but throughout the nation, not only for physicians but for their patients as well. It is encouraging that the House of Delegates

yesterday endorsed the society's previous position on this matter. This position includes: (1) Support of legislation in the General Assembly to establish a reinsurance pool to assure continued availability of coverage. As you know, House Bill 74, proposed by our own Physician-Representative John Gamble, was approved overwhelmingly by the House on Wednesday and will now go to the Senate; (2) Support of the concept of a Legislative Study Committee to investigate statutory changes needed in our laws to improve the insurance climate in North Carolina. This will also serve to educate the public that these changes are essential if the delivery of their health care is to continue uninterrupted.

Dr. David Bruton, chairman of the Committee on Legislation, and our legislator-at-large, Dr. Ed Beddingfield, continue their good work with the General Assembly.

Amid these many and highly significant problems, is there any *good* news? Yes, I believe so—quite definitely. We have a strong society which has just completed a busy and productive year under the able leadership of Dr. Frank Reynolds, to whom each of us is indebted.

Our membership is the largest ever, now numbering 4,500 members. Increasingly, more of our members are participating in the society's work; our headquarters facilities and reorganized staff are superior to any we have known before; and our auxiliary support is strong. The public trusts and respects medicine—as opinion polls continually show—at a time when public respect and trust of our institutions are at a historic low.

In North Carolina, PSRO is functioning with good physician support. The North Carolina Medical Peer Review Foundation and its staff, under the exceptionally able guidance of Dr. Frank Sohmer, are to be commended for an exemplary job. PSRO is law, and though we resent the interference of governmental regulations, we do obey the law while at the same time work to modify and improve its oppressive features. Our favorable experience with PSRO so far lends encouragement that other mandated regulatory measures might also be implemented in a palatable or at least a livable form—if we can provide the leadership and the widespread cooperative participation that will be needed.

North Carolina has been a leader in the development of Area Health Education Centers. The AHEC program is rapidly unfolding and maturing throughout the state, producing better health care through better and more sophisticated education delivered in every section of North Carolina. I know of no better example of how productive the cooperative efforts of physicians of different types can truly be—in this instance the cooperation of academicians with practicing physicians.

What do we do now and in the coming year? You have just installed a new set of officers. I have met with the other officers and would like to spend the



Dr. James E. Davis

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remaining minutes this morning on what we would like to accomplish this year as a team.

Quite simply, we want to lead and to speak for you to the very best of our abilities. In order to do this we must know how you feel about issues and what your needs are.

In this past year, as president-elect, I have spent literally hundreds of hours attending society meetings, committee meetings and hearings on governmental matters, as well as listening to hundreds of individual society members. There is a feeling among many of you that you are not an important part of this society, that you are not in the mainstream of medicine in North Carolina and that there is little concern about you and your problems.

The presidents before me have each increased their efforts each year toward getting timely and helpful information to you by way of the *President's Newsletter*, the *Public Relations Bulletin*, the *NORTH CAROLINA MEDICAL JOURNAL*, and increasingly by use of our outgoing WATS telephone line. I intend to continue and intensify these efforts to keep you informed. What we most need now is for you to keep us informed—informed of what *you* think our problems are, how *you* think we can solve them, what *you* need in order to do a better job and how *your* state organization can help you.

Since there are 4,500 of us, divided into 78 component county medical societies, 16 specialties and some 70 sub-specialties, it is apparent that we have a lot of listening to do.

To accomplish this two-way communication, we are scheduling a series of regional meetings throughout the state which will begin almost immediately and will be held at locations easily accessible to you. The auxiliary and the entire headquarters staff will participate with us in the staging of these meetings. Every physician of the visited area, whether a medical society member or not, will be invited to attend with his wife. Officers of the society, members of the headquarters staff and experts in such matters as legislation, professional liability insurance, PSRO, Health Service Areas and health system agencies will come to our area to talk with and to listen to you. We are already investigating where and when these meetings would be most convenient to you and the times and locations will be announced to you shortly.

We now have good geographic distribution of our officers, with a president in Durham and Raleigh, a

president-elect in Gastonia, a vice president in Wilson, and another in Shelby. In addition to these planned regional meetings, we are anxious to attend your county medical society meetings and other forums in which a free two-way exchange of information can be provided as often as possible.

The society now has four of its staff members who are involved in varying degrees of field work, each of them possessing various areas of expertise. They will be able to provide better contact with you and your officers than ever before.

In short, your society and your officers want to communicate. We want to hear from you in person, by telephone, or by letter—and you will receive a reply.

If my year as president is to have a goal, it is *Unity and Greater Participation*, which I feel will result from the better mutual understanding which improved communication will bring us.

As large and as diverse as our society is, as varied as our practices and individual personalities are, we have much in common. The most important thing we have in common is that all of us are dedicating our lives and efforts—in our own diverse ways—to producing better medical care.

Yet, our system of medicine is rapidly being changed by those who frequently are uninformed and misdirected. We must, therefore, put aside all differences among ourselves and unify our efforts to see that the true values of medicine are preserved and continually improved. Physicians must be heard and heard with a more authoritative voice. We—your spokesmen—can speak authoritatively only if you keep us informed of your thoughts and opinions so that we can accurately reflect them to the public, to the media and to our patients—to all of whom we must be accountable.

From my viewpoint, then, medicine is troubled and is undergoing vast change. The system of medical care which will evolve from these transitional years is one with which we will live and work for decades to come.

We now have our chance—perhaps the last—to truly help to decide what this system will be. Our success depends on our ability to speak clearly through organizations like the North Carolina Medical Society and the American Medical Association which represent the entire profession and are recognized by the public as doing so. We are coming to you to learn how you best want to be represented. Please join us and let's talk!

Regionalized Perinatal Care: An Estimate of Its Potential Effect on Racial Differences in Perinatal Mortality in North Carolina

Gary S. Berger, M.D., J. Richard Udry, Ph.D.,
and Charles H. Hendricks, M.D.

IN North Carolina, as throughout the United States, mortality rates for nonwhites exceed those for whites at almost all periods of life, including the perinatal. Effective July 1, 1974, a program of regionalized perinatal care was undertaken in North Carolina with the goal of reducing morbidity and mortality through provision of adequate prenatal care and obstetrical delivery of high risk patients in regional centers equipped to handle complications, and through development of regional centers for intensive care of the high-risk neonate. Because of the increased relative risk of perinatal mortality among nonwhites, one result of regional perinatal care might be to narrow the gap in perinatal mortality between the white and nonwhite population in North Carolina. This report attempts to predict the degree to which such a public health program might reduce excess perinatal mortality among nonwhites.

Methods

All registered live births, fetal deaths and neonatal deaths matched to live births in North Carolina from

January 1, 1970, through December 31, 1972, were analyzed. These vital data are made available to the public on magnetic tape by the Public Health Statistics Branch of the North Carolina Division of Health Services. Perinatal mortality rates for the United States were obtained from published United States Vital Statistics volumes.

Perinatal mortality includes fetal deaths of 20 weeks or more gestation and infant deaths under 28 days. The perinatal mortality rate is defined as the number of perinatal deaths per 1000 live births plus fetal deaths of 20 weeks or more gestation. For the sake of simplicity, perinatal mortality is not separated into its two component parts in this report. However, analysis of these data revealed similar results for fetal and for neonatal mortality rates as for the perinatal mortality rates shown in tables I, II and III.

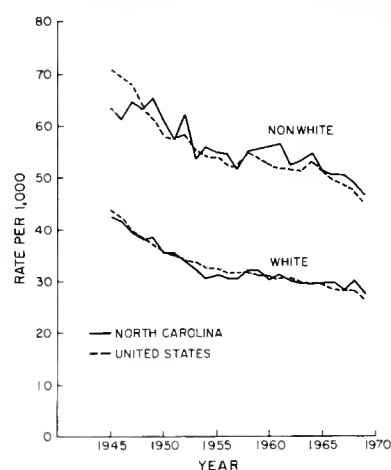
Results

Figure 1 illustrates the trend in perinatal mortality for whites and nonwhites in North Carolina and in the United States from 1945 through 1969. The rates for whites and nonwhites have been declining. Although nonwhite mortality has shown a greater absolute decline, there has been little reduction in the relative difference in perinatal mor-

tality between the races. Nonwhite mortality has consistently been 60 to 70 percent higher than white mortality, both in North Carolina and in the nation. This relative difference persisted in North Carolina in the period 1970-1972, during which the crude perinatal mortality rate was 25.7 for whites and 41.0 for nonwhites. Thus, in order to achieve a rate equivalent to that of the white population, the perinatal mortality rate among nonwhites would have to be reduced by 40 percent.

Of the factors associated with perinatal mortality, fetal maturity at the time of delivery is the most critical. It is generally appreciated that

FIG 1 PERINATAL MORTALITY RATES BY RACE, NORTH CAROLINA AND UNITED STATES, 1945-1969



From the Departments of Obstetrics and Gynecology and Maternal and Child Health, University of North Carolina at Chapel Hill

Table I
Percent Distribution of Deliveries and Perinatal Mortality Rates
By Birthweight, Gestation and Race
North Carolina, 1970-1972

Birthweight and Gestation	White		Nonwhite	
	Percentage of Births	Mortality Rate/1,000	Percentage of Births	Mortality Rate/1,000
2000 grams or less				
≤34 weeks	2.2	566.2	4.6	504.9
≥35 weeks	0.8	305.1	1.4	273.2
2001 grams or more				
≤34 weeks	2.7	56.7	8.0	33.8
≥35 weeks	94.3	9.8	85.9	12.7
TOTAL	100.0	25.7	100.0	41.0
	N=200,246		N=84,945	

Excludes cases with unknown birthweight or gestation.

both birthweight and gestational age must be taken into account in defining an index of maturity since infants of a given birthweight do not necessarily represent a homogeneous group with respect to gestational age or vice versa. Therefore, in Table I, we compare white and nonwhite mortality rates for various birthweight-gestation groups. The decision to divide the groups into the birthweight and gestation categories as shown was based on the recommendation of a task force which drew up the proposal for the Regional Perinatal Health Care Program to identify newborns of 2000 grams or less or under 35 weeks gestation as high risk infants requiring observation and intensive care, where necessary, in the more sophisticated regional hospitals.¹

In addition to the mortality rate in each birthweight-gestation category, Table I shows the percent of deliveries occurring in that category for each race group. For a given birthweight and gestation, the perinatal mortality rates for whites and nonwhites are fairly similar. In fact, the risk of mortality for nonwhites is less than that for whites in all groups except for over 2000 grams and 35 weeks or more. However, the likelihood of a nonwhite infant being born at low birthweight and/or prior to 35 weeks, with the attendant increased risk of death, is over twice as great as for a white infant. The racial difference in crude mortality rates is obviously related to the differences in distribution of births by birthweight and gestation for whites and nonwhites.

Table II presents perinatal mortality rates, with the corresponding number of deliveries, for whites and nonwhites controlled for adequacy of prenatal visits, type of hospital in which delivery occurred, birthweight and gestation. The number of prenatal visits and time of first visit do not necessarily reflect the quality of prenatal care, but this is the best indicator possible from vital statistics records. The definition of "adequate" prenatal visits is that given in the recent report, "Infant Death: An Analysis by Maternal Risk and Health Care,"² and is consistent with the recommendations of the American College of Obstetricians and Gynecologists. The categories of hospitals are defined as follows: "A Hospitals" consist of 5 institutions* which provide the most sophisticated obstetrical and neonatal services in the state, and thus come closest to providing the services of the "Level II-III" type facilities under the new program. All other hospitals are included in the category "B Hospitals." Since cases with unknown prenatal visits or delivery outside a hospital are excluded from this table, the total birthweight and gestation-specific rates are slightly, but not significantly, different from those in Table I.

For each race, within a given birthweight-gestation group, there is no consistent trend of improved outcome for patients with adequate prenatal visits and/or delivering in Class A Hospitals. However, by

*Baptist, Charlotte Memorial, Duke, North Carolina Memorial and Wake County Memorial

applying the lowest rate within each race-birthweight-gestation group to the total population at risk in that group, which is a possible target for the program, an estimate of the maximum likely reduction in perinatal mortality can be obtained. How this is to be done without any impact from hospital selection and improved prenatal care is another question. According to this calculation, an estimated 14 percent reduction in perinatal mortality is obtained for nonwhites and 11 percent for whites. Although this would represent some gain in narrowing the gap in perinatal mortality between whites and nonwhites, it would be minor (a five percent reduction in the relative excess nonwhite mortality).

An alternative estimate of the effect of the Perinatal Care Program can be based on the assumption that the program would result in nonwhite infants having the same risk of mortality as white infants of comparable birthweight and gestation, but would have no effect on the maturity of the infant at time of delivery. Because of the relatively higher mortality rates of whites at low birthweight and gestation, this would result in a net increase of six percent in the excess perinatal mortality of the nonwhite population. However, the difference in the crude perinatal mortality rates would be virtually eliminated if the nonwhite population had the same distribution of deliveries by gestation and birthweight as the white population, even if no change occurred in the present gestation-birthweight specific mortality rates for each race.

It may be appreciated that the first estimate of the effect of the program mentioned above—applying the lowest rate associated with adequacy of prenatal visits or hospital category to the entire race group for a given birthweight and gestation—does not take into account differences in medical characteristics of the populations in the two groups of hospitals. Thus, the failure to observe a significant reduction in perinatal mortality associated with delivery in A Hospitals may be due to an inherently

Table II
Number of Deliveries and Perinatal Mortality Rates by Adequacy of Prenatal Visits,
Hospital Category, Birthweight, Weeks of Gestation, and Race
North Carolina, 1970-1972

Prenatal Visits and Hospital	White				Nonwhite			
	2000 grams or less		2001 grams or more		2000 grams or less		2001 grams or more	
	≤34	≥35	≤34	≥35	≤34	≥35	≤34	≥35
Adequate Visits								
A Hospitals	581.2 (117)	183.7 (49)	102.7 (146)	9.5 (6842)	613.6 (176)	147.5 (61)	27.9 (323)	9.9 (4835)
B Hospitals	575.5 (2271)	282.9 (852)	55.6 (3092)	9.0 (142, 149)	526.7 (917)	266.9 (266)	31.6 (1900)	12.6 (25, 250)
Inadequate Visits								
A Hospitals	625.9 (147)	267.9 (56)	35.5 (141)	13.3 (2941)	470.5 (576)	259.4 (212)	28.0 (822)	9.5 (7351)
B Hospitals	533.4 (1721)	333.3 (684)	54.3 (1952)	12.4 (35, 519)	473.3 (2026)	269.6 (638)	33.7 (3292)	13.3 (32,116)
TOTAL	560.4 (4256)	300.4 (1641)	55.9 (5331)	9.7 (187, 451)	492.8 (3695)	260.8 (1177)	32.0 (6337)	12.4 (69,552)

Excludes cases with unknown prenatal visits, birthweight, gestation, or delivery outside hospital

higher risk of this population. However, since most of the medical conditions which can be successfully treated by intensive neonatal care are associated with low birthweight and/or preterm delivery, controlling for birthweight and length of gestation should minimize this potential bias. The effect of bias resulting from referral of high risk patients to the A Hospitals can be reduced further by excluding from analysis the patients who were delivered outside the mother's county of residence. As shown in Table III, exclusion of out-of-county deliveries does not change the inevitable conclusion that birthweight and gesta-

tion at delivery are far more important determinants of perinatal mortality than the type of hospital providing obstetrical and neonatal care or the number of prenatal visits made by the time of delivery.

Comments

The implementation of the Regional Perinatal Health Care Program represents a major clinical and public health effort to deal with the problems of poor pregnancy outcome in North Carolina. Providing adequate prenatal care to all women should be of benefit because of the association with prematurity of certain factors in pregnancy, such as

toxemia, placenta previa, incompetent cervix and Rh incompatibility. Effective preventive obstetrics can control these factors to some degree. However, they account for a small proportion of cases of prematurity, and it is doubtful whether prenatal care can play a major role in preventing the majority of premature deliveries. The creation of intensive obstetrical and neonatal centers is also likely to be of benefit in the treatment of specific medical conditions, but it is apparent that at the time of delivery it is too late to change the degree of maturation of the infant.

On the basis of the various esti-

Table III
Number of Deliveries and Perinatal Mortality Rates by Adequacy of Prenatal Visits,
Hospital Category, Birthweight, Gestation, and Race for County Residents Only:
North Carolina, 1970-1972

Prenatal Visits and Hospital	White				Nonwhite			
	2000 grams or less		2001 grams or more		2000 grams or less		2001 grams or more	
	≤34	≥35	≤34	≥35	≤34	≥35	≤34	≥35
Adequate Visits								
A Hospitals	582.4 (91)	279.1 (43)	90.1 (111)	9.3 (5695)	598.5 (132)	163.3 (49)	23.4 (256)	10.5 (4095)
B Hospitals	565.5 (1724)	273.3 (677)	55.0 (2400)	8.8 (112, 855)	518.3 (766)	262.0 (229)	28.6 (1644)	11.7 (21,431)
Inadequate Visits								
A Hospitals	592.2 (103)	250.0 (36)	10.3 (97)	13.7 (2116)	455.4 (448)	230.3 (152)	15.3 (653)	8.6 (5668)
B Hospitals	528.3 (1327)	334.0 (539)	54.8 (1552)	12.2 (27,328)	466.1 (1697)	285.5 (543)	32.7 (2749)	13.1 (26, 041)
TOTAL	551.6 (3245)	298.1 (1295)	54.8 (4160)	9.5 (147, 994)	483.4 (3043)	265.2 (973)	28.9 (5302)	11.9 (57, 235)

Exclude cases with unknown prenatal visits, birthweight, gestation or delivery outside hospital or county of mother's residence

mates derived above, it appears that significant control of excess perinatal mortality among nonwhites will depend on the prevention of prematurity. Since the prematurity rate for nonwhites has been increasing during the past two decades while that for whites has remained stable,³ the concept of preventing prematurity assumes even greater significance.

Unfortunately, simply calling attention to this major problem underlying the excess perinatal mortality of the nonwhite population does not necessarily imply that the solution to the problem is near. In view of the complex interaction of the multiple social, economic, nutritional, educational and biological factors associated with prematurity, it is apparent that efforts to control the problem require a multifaceted attack of which regionalization of perinatal health services may be

viewed as one element. However, until the present relatively inadequate state of knowledge regarding the etiology of prematurity is improved, it seems reasonable to suggest that there will continue to be a significant gap between the races in the risk of perinatal mortality. There is little likelihood that regionalized perinatal care will have an impact on the race differential in perinatal mortality.

SUMMARY

In 1970-1972 the crude perinatal mortality rate in North Carolina was 25.7 for whites and 41.0 for nonwhites. The excess mortality rate for nonwhites is consistent with the pattern that has been documented ever since vital statistics have been recorded in this country.

When controlled for birthweight and length of gestation, perinatal mortality rates for nonwhites were

not significantly higher than for whites, and there were no significant differences in outcome by adequacy of number of prenatal visits or by type of hospital in which delivery occurred (with or without a neonatal intensive care unit).

These observations suggest that progress in eliminating the gap between the races in perinatal mortality in North Carolina will require control of the excess rate of prematurity among the nonwhite population, rather than simply providing more intensive prenatal or neonatal care services.

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3. National Center for Health Statistics: Trends in "Prematurity," United States: 1950-1967. *Vital and Health Statistics*. DHEW Publication No. (HSM) 72-1030 Series 3-No. 15. Public Health Service. Washington, U. S. Government Printing Office, 1972.

When he was fairly inside the Thacker kitchen, the benefaction of his presence was felt by every one. It was most touching to see the patient's face lose its worried look, and grow quiet and comfortable as if here were some one on whom she could entirely depend. The doctor's greeting was an every-day cheerful response to the women's welcome, and he stood for a minute warming his hands at the fire as if he had come upon a commonplace errand. There was something singularly self-reliant and composed about him, one felt that he was the wielder of great powers over the enemies, disease and pain, and that his brave hazel eyes showed a rare thoughtfulness and foresight. The rough driving coat which he had thrown off revealed a slender figure with the bowed shoulders of an untiring scholar. His head was finely set and scholarly, and there was that about him which gave certainty, not only of his sagacity and skill, but of his true manhood, his mastery of himself.

—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 32-33.

High Incidence of Extrapulmonary Tuberculosis In a General Teaching Hospital

David L. Smith, M.D.,* Robert J. Snowe, M.D.,†
and Thomas R. Cate, M.D.

A SEEMINGLY large proportion of extrapulmonary tuberculosis in patients in a general teaching hospital prompted a review of the disease. Even though patients known to have tuberculosis were not routinely treated in this hospital, there was strong or conclusive evidence of the infection in 0.2 percent (126) of inpatients and nine outpatients seen during three years. Extrapulmonary disease occurred in 43 percent (58) in contrast to 10.6 percent of new cases in the United States in 1970.¹ The modes of presentation and diagnoses illustrate many effects of tuberculosis and indicate the need for education and control programs in general hospitals.

MATERIALS AND METHODS

Duke Hospital, an 800-bed general teaching hospital admitting more than 20,000 patients a year, routinely treats no tuberculosis patients except those referred for surgery from sanatoriums. Here we studied 135 patients, using records of all patients with tuber-

culosis seen from January 1, 1967, through December 31, 1969, all records with a discharge diagnosis of tuberculosis, positive culture reports for *M. tuberculosis* from the mycobacteriology laboratory and surgical pathology and autopsy reports with diagnoses of tuberculosis. Classifications were: (1) Definite tuberculosis (92 patients): *M. tuberculosis* was recovered from one or more specimens and patients had usual signs and symptoms; and (2) Probable tuberculosis (43 patients): *M. tuberculosis* was not recovered, although the illnesses appeared to be tuberculosis, meeting these criteria: (a) intermediate tuberculin skin test with 10 mm or greater duration; (b) biopsy consistent with tuberculous granuloma; (c) acid-fast bacilli (AFB) in specimens from the area of the disease; and (d) improvement with antituberculous therapy. An acetylcytosteine-alkali digestant procedure and Ziehl-Neelsen staining were used, and *Mycobacterium tuberculosis* was identified by customary techniques. Tuberculin, Purified Protein Derivative from *M. tuberculosis* var. *hominis* (PPD) purchased from Parke-Davis, was not stabilized with Tween-80. Induration of less than 4 mm was classified as a negative reaction, 5-9 mm

as doubtful and 10 mm or greater as positive.

RESULTS

General characteristics of the patients: Histories of tuberculosis were obtained from ten patients and exposure to tuberculosis from 30 others including five health professionals. In most cases it was not possible to determine whether and when isolation procedures were used; 55 were hospitalized for 11 days or longer before receiving antituberculous therapy; and the diagnosis was not made for two patients until autopsy.

It is uncertain whether the distribution of associated diseases among the 135 patients—including malignancy (10), severe alcoholism (10), chronic obstructive pulmonary disease and/or emphysema (5), diabetes mellitus (4), collagen vascular disease (2), and pemphigus vulgaris treated with steroids (1), and cardiovascular and/or cerebrovascular disease in many elderly patients—differed from that of comparable non-tuberculous patients. Age distribution is shown in Figure 1 by sex and race.

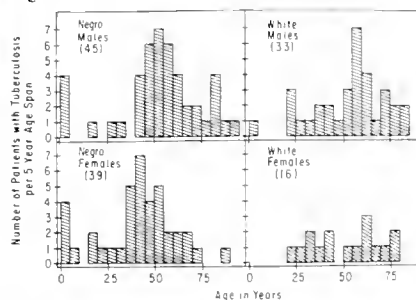
Organ involvement by tuberculosis: Sites of tuberculosis are listed in Table 1: About one-seventh (19 of 127) of the patients with localized

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Fig. 1



infection had involvement of more than one organ system; patients with disseminated miliary tuberculosis are not included under the organ systems involved.

Pulmonary tuberculosis. This localized disease occurred in 91 (67 percent) of the patients, most of whom were referred because they had abnormal chest X-rays. AFB were seen on smear in four percent of the minimally advanced cases, and in 64 and 86 percent of moderately and greatly advanced tuberculosis. *M. tuberculosis* was cultured from sputum, gastric aspirate and/or bronchial wash specimens from 66 of 81 patients. Sputum cultures were positive in 70 percent of those with minimally active disease, and in 86-88 percent with advanced illness. Gastric aspirate cultures, taken when patients could not produce good sputum specimens, were positive in seven patients. In six of seven no other culture was positive.

Extrapulmonary tuberculosis. Fifty-eight (43 percent) patients had one or more manifestations of extrapulmonary disease:

Miliary tuberculosis: A six-month-old black boy and seven adults (five black; four men) had miliary disease. Associated disorders were severe alcoholism (2),

multiple myeloma (1), lymphocytic leukemia (1) and lymphoma (1). Admitting diagnoses were: Infant—miliary tuberculosis; one adult—fever of undetermined origin or tuberculosis; and, the remaining six—lymphoproliferative disorder (3), sarcoid (1), extensive metastatic carcinoma (1) and Wernickes encephalopathy (1). Seven patients had lung X-rays compatible with miliary disease. AFB were found in sputum smears, gastric aspirate or bronchial washings from four of six patients. Granulomatous change suggestive of tuberculosis was observed in bone marrow sections (3) and in lymph node (2), liver (2), pleura (1) and pharyngotonsillar biopsies (1).

Of six patients who had tuberculin skin tests, three were negative with first strength, all were positive with second strength (at least 18 mm induration), and one of three was positive at intermediate strength.

Pleural tuberculosis: Twenty-two patients had proved or probable pleural tuberculosis. Six had only pleural disease and 16 had tuberculosis at other sites including lungs, pericardium, peritoneum, genitourinary tract, lymph nodes and vertebral bodies. Admission diagnoses included metastatic malignancy, cirrhosis with effusion, pneumonia with empyema and collagen vascular disease.

Pleural fluid specimens from 17 patients were examined. Except for three (two of these were too thick to examine), the fluids were exudates, i.e., with specific gravity greater than 1.015 and protein count greater than 3.0 g percent. Pleural fluid WBC counts ranged from 146-9,750 cu mm with differentials of 0-50 percent polymorphonuclear cells and 50-100 percent lymphocytes, and RBCs varied in number. The smears showed no AFB, but *M. tuberculosis* was recovered from the two thick exudates and from three of the remaining 15 patients. Two other patients subsequently had positive cultures in association with continued disease.

Cope needle biopsies of pleura were obtained from 10 patients. Granulomas were in seven and organizing exudate in three. No AFB

were seen but one of the specimens yielded *M. tuberculosis* on culture despite a negative pleural fluid culture.

Tuberculosis of bones and joints: Twelve adults and a 26-month-old child had this form of disease. Differential diagnoses included metastatic malignancy or pyogenic bacterial infections. Sites affected were the spine ranging from the fourth thoracic to the fifth lumbar vertebra (7), hip (2), elbow (2), wrist (1), metacarpal bone (1) and knee (1). All but one patient, who had tuberculous arthritis of the knee and elbow, had solitary sites of skeletal involvement. Five patients had histories of trauma to the affected bone/joint. Seven of 13 had X-ray evidence of active pulmonary tuberculosis and two others had only minimal pulmonary scarring.

Eleven of 13 patients had aspiration/biopsy of the affected bone or joint. AFB were seen in two tissue specimens, one from a man receiving isoniazid (INH) who subsequently failed to produce *M. tuberculosis*, and were cultured from ten specimens. The two patients who did not have aspiration/biopsy had spinal involvement; one subsequently had a positive culture from another site. All patients skin tested with IPPD had at least doubtful reactions, and seven of nine yielded induration of greater than 14 mm diameter.

Tuberculous lymphadenitis: The lymph node disease in six adults was major or the only manifestation of tuberculosis. Lymph node groups involved were: axillary (2), mediastinal, scalene and axillary (1), cervical (1), cervical and right hilar (1) and supraclavicular (1).

Differential diagnoses included lymphoma, metastatic carcinoma and a variety of infections including tuberculosis. Four had no evidence of tuberculosis other than lymph nodes. Thick pus was obtained from the node masses in three patients; none of the specimens was smear positive for AFB but they yielded *M. tuberculosis* on culture. Antituberculous therapy was not promptly begun and drainage from the node sites was prolonged.

Node biopsies were performed on

Table 1

Clinically Evident Organ Involvement in 135 Tuberculosis Patients

Organ	Number	Percent
Miliary Tuberculosis	8	6
Localized Tuberculosis		
Lung	91	67
Pleura	22	16
Bone and Joint	13	10
Lymph Node	6	4
Pericardium	6	4
Genitourinary Tract	4	3
Central Nervous System	4	3
Peritoneum	3	2
Nasopharynx	1	1
Multiple Organs (excluding miliary)		
Two 15	19	4
Three 4	2	3

the other three patients and the surgical wounds healed without drainage, perhaps aided by early institution of antituberculous therapy. Granulomas were seen on each specimen, caseation twice and AFB twice. Only two of the biopsies were cultured and both yielded *M. tuberculosis*.

Tuberculous pericarditis: The six patients with tuberculous pericarditis had two types of presentations, one distinguished by a subacute course (weeks), fever and an enlarged cardiac silhouette, and the other a chronic course (months), no fever and a cardiac silhouette of normal size. X-ray showed active pulmonary disease in one and four had exudative pleural effusions. Exudative pericardial fluid was obtained from the three patients with a subacute course. AFB organisms were seen on one pericardial fluid, but specimens from two yielded *M. tuberculosis* on culture. Pericardectomies revealed granulomatous pericarditis in four. One died 17 days post-pericardectomy.

Genitourinary tuberculosis: Four adults had histologic evidence of tuberculosis involving the epididymis (2), prostate (1), endometrium (1) and side wall of the pelvis (1).

Four others had positive urine cultures for *M. tuberculosis*; three had miliary tuberculosis and the fourth was an alcoholic with minimal pulmonary tuberculosis, pyuria, hematuria and a normal intravenous pyelogram (IVP), who may have had minimal renal tuberculosis or hematogenous dissemination without overt miliary disease.

Tuberculosis of the central nervous system: Three children (ages 13-36 months) presented with meningeal irritation and fever of two to three weeks' duration and other neurological signs. Only one had an abnormal chest X-ray, showing a right perihilar infiltrate. Cerebrospinal fluids revealed a pleocytosis of 11-200 white cells/cu mm with 40-78 percent lymphocytes, protein of 133-300 mg/dl, and glucose 3-30 mg/dl. None had positive cultures/smears for pathogenic bacteria, fungi or *M. tuberculosis*. Two had positive IPPD skin tests and one had only a positive second

Table 2
PPD Skin Test Results for Patients with Culturally Proved *M. tuberculosis* Infection

PPD Strength	Number of Patients Tested*	Number of Patients with Indicated Skin Test Reactions	
		Doubtful†	Positive‡
First	25	0	14 (56%)
Intermediate	42§	2	24 (57%)
Second	12	0	7 (58%)

*54 patients were skin tested with only 1 strength, 8 with 2 strengths, and 3 with 3 strengths, representing 79 skin test results in 65 patients.

†5-9 mm of induration

‡10 or more mm of induration

§Includes 3 Tine tests (2 "negative" and 1 "positive.")

strength PPD skin test. A history of close contact with tuberculosis was obtained from two or three children. All patients improved with antituberculous therapy; they probably had tuberculous meningitis. Another patient had a left cerebellar tuberculoma, a diagnosis based on 15-20 AFB per slide in the neurological tissue specimen and improvement with antituberculous therapy.

Skin test results: Results of tuberculin skin tests were not recorded for 44 of 135 patients with proved or probable tuberculosis. This data for patients with culturally proved *M. tuberculosis* are summarized in Table 2. The percentage of positive reactions with each PPD strength was 56-58 percent (Table 2). Failure to observe a significantly increasing percentage of positive skin tests with increasing PPD concentrations was due in part to proceeding to higher strengths only in patients who had failed to respond to initial testing with lower strength material. However, even if the positive reactions to first strength PPD are combined with the results of IPPD testing, the proportion of those with positive reactions is only 38 of 56, or approximately two of three. Of seven patients who were intermediate negative and tested to second strength, five of seven, or 71.4 percent, were positive. Only seven of 12 (58 percent) who were tested with the strongest PPD preparation, second strength, had positive reactions. Few results of repeated PPD skin tests and tests for generalized anergy were available.

DISCUSSION

Approximately 0.2 percent of patients seen at Duke Hospital from 1967 through 1969 had proved or

probable tuberculosis. The diagnosis was made for the first time in 94 percent of our patients, being similar to a study in a general hospital in Toronto in which 0.13 percent of admissions had pulmonary tuberculosis, previously undiagnosed in 74 percent.²

Age, race and sex distributions of our patients were similar to those of the United States^{1,3} except that a greater proportion of less common forms of tuberculosis was seen in our study, probably because pulmonary cases were diagnosed in the community and sent directly to sanatoriums, whereas complex cases were referred to tertiary centers for diagnosis. For example, the 1970 United States incidence of extrapulmonary tuberculosis was 10.6 percent of all new cases,¹ in contrast to 43 percent of 135 patients in the present series.

Forty-eight percent of the 91 patients with pulmonary tuberculosis were diagnosed by sputum smear alone. The percentage of positive sputum smears varied with the extent of disease shown on chest X-rays, emphasizing the difficulty of making a diagnosis in minimally active disease with small numbers of organisms being excreted. The decision to initiate therapy must be made on a sensitive appraisal of the patient, rather than the results of a negative AFB smear.

First strength and intermediate strength tuberculin skin tests were rarely positive in the eight patients with miliary tuberculosis, but second strength tests were often positive, indicating that these patients may have had depressed, but not absent, delayed hypersensitivity. In several cases, biopsies were important for early diagnosis. The

one patient who died with unrecognized miliary tuberculosis lacked radiological evidence of the disease on her initial chest X-ray, which reaffirms that roentgenograms cannot be relied upon as an early clue.⁴ Because mortality from miliary tuberculosis is high, awareness, rapid diagnosis and early therapy are imperative.

In evaluating patients with pleural tuberculosis, thoracenteses continued to be a valuable technique, confirming exudative effusions with no greater than 50 percent polymorphonuclear cells. Tissue obtained by cope needle revealed granulomata in 70 percent of those undergoing pleural biopsy.

Ten percent of our patients had bone and joint tuberculosis, the spinal column and hip affected in 71.4 percent of the cases. The probabilities of skin reactivity to PPD and of recovery of *M. tuberculosis* by culture when specimens were obtained from the site of involvement were high. Biopsies showing granulomatous inflammation were useful for early diagnosis, but AFB were rarely seen despite positive cultures. Additional observations were the infrequent involvement of more than one skeletal site, the lack of disease in any other organ system in four of 13 patients and the history of trauma to the site of involvement in five patients. A diagnosis of lym-

phatic tuberculosis was best accomplished by excisional biopsy of an involved node, permitting early therapy.

A subacute or chronic presentation was observed in patients with tuberculous pericarditis, and cardiac tamponade or constrictive pericarditis was observed in both groups; also noted were the usual absence of active pulmonary tuberculosis by X-ray and the presence of exudative pleural effusions.

The few patients we saw with unusual forms of extrapulmonary tuberculosis must be considered in the differential diagnosis of pathology in those areas.

About one-third of our patients with culturally proved tuberculosis had negative skin reactions to IPPD, possibly surfaces of vials and syringes absorbed PPD; however, according to a study by Holden et al.⁵ even when using an IPPD stabilized with Tween-80 and a nurse trained in skin test techniques, 19.1 percent of their culturally proved tuberculous patients were nonreactive. Moreover, in our series, five of 12 patients tested remained nonreactive to second strength PPD. This data suggests that when the 5 TU tuberculin test, with or without Tween-80, is used as a diagnostic maneuver in the acutely ill patient, there is a 20 to 30 percent false negative reaction.

SUMMARY

Approximately 0.2 percent (126) of patients hospitalized in a general teaching hospital and nine outpatients seen from 1967 through 1969 were diagnosed as having tuberculosis. *Mycobacterium tuberculosis* was cultured from 92 patients and 43 met criteria for probable tuberculosis. Pulmonary disease was present in 67 percent (91), but 43 percent (58) had one or more foci of extrapulmonary disease including miliary (8), pleural (22), bone and/or joint (13), lymph node, as a predominant manifestation (6), pericardial (6), genitourinary (4), central nervous system (4), peritoneal (3) and nasopharyngeal (1) tuberculosis.

General hospitals, even those which usually do not treat patients with tuberculosis, should be alert to the disease, particularly to extrapulmonary manifestations.

ACKNOWLEDGMENT

Supported by U.S.P.H.S. grants ES-00124 (Drs. Smith and Cate) and HD-00132 (Dr. Snowe).

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Nan had already found plenty of wild flowers in the world; there were no entertainments provided for her except those the fields and pastures kindly spread before her admiring eyes. Old Mrs. Thacher had been brought up to consider the hard work of this life, and though she had taken her share of enjoyment as she went along, it was of a somewhat grim and sober sort. She believed that a certain amount of friskiness was as necessary to young human beings as it is to colts, but later both must be harnessed and made to work. As for pleasure itself she had little notion of that. She liked fair weather, and certain flowers were to her the decorations of certain useful plants, but if she had known that her grand-daughter could lie down beside the anemones and watch them move in the wind and nod their heads, and afterward look up in the blue sky to watch the great gulls above the river, or the sparrows flying low, or the crows who went higher, Mrs. Thacher would have understood almost nothing of such delights, and thought it a very idle way of spending one's time.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 50-51.

Editorials

PERINATAL CARE, PLANNING AND PROTEIN

To relate the delivery of perinatal care to the achievements of Nobel Prize winners outside medicine may seem overreaching but the report by Berger and his colleagues in this issue of the JOURNAL warrants such an effort because of the economic and social implications of their study. The story begins in 1944 with the publication of Gunnar Myrdal's illuminating *An American Dilemma: The Negro Problem and Modern Democracy*, in which he posed with great care the question of how the United States would cope with the economic and social aspirations of its growing black population. Twenty years later, Myrdal of Sweden shared with Austrian economist Friedrich A. Von Hayek the Nobel Prize for economic science. Hayek had published, also in 1944, his best known work, *The Road to Serfdom*, in which he espoused limited government and personal freedom while decrying central planning and the elaborate governmental superstructures necessary when such controlling systems are established. He did consider that government was obligated to maintain an honest currency, to confirm the individual in his rights with an adequate judiciary, to tend the health of the public as part of its responsibility for the general welfare and to protect itself militarily.

Berger's study testifies to our efforts to decrease the excess perinatal mortality noted by Myrdal as one of our continuing challenges and suggests that an excessive rate of prematurity rather than insufficient pre-

natal or neonatal service is at fault. Hayek would probably agree that further steps are now required since the non-white population is needier and requires relief from the desperation of their need if they are to enjoy the benefits of and contribute to a stable society¹.

If more intensive medical care is insufficient despite its great value for the newborn sick and the number of prenatal visits makes little difference, where are we to turn? Since the mother's nutrition and the baby's birth weight are strongly related to socioeconomic status², it is obvious that we must examine the provision of adequate nourishment, especially of protein, since protein lack is reflected in retardation of fetal growth, particularly of the brain. It has been suggested that nutritious foods can be provided at about \$100 per pregnancy (1972-1973 dollars) while care of a deficient child costs about \$100,000 per lifetime². Few can argue against programs directed toward improving nutrition and decreasing perinatal mortality; the difficulty lies in the design, in achieving maximum benefit from limited dollars which will become more limited with increasing competition for funds from federal and state governments which may not heed Hayek's advice to keep currency clean. Perhaps Myrdal's book should be retitled *The American Dilemma: Modern Democracy*.

References

1. Chamberlain J: The "Unknown" Nobel Prize Winner, Wall St Jour Oct. 24, 1974.
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WHAT? WHEN? WHERE? In Continuing Education

August 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category I" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

September 5-6

North Carolina Chapter of the American Academy of Pediatrics and The North Carolina Pediatric Society—Annual Meeting
 Place: Blockade Runner, Wrightsville Beach
 For Information: Mrs. John McLain, Executive Secretary, 3209 Rugby Road, Durham 27707

September 12-13

Two Days of Stroke
 Fee: \$50
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 12-13

1975 Walter L. Thomas Symposium on Gynecologic Malignancy and Surgery. Main emphases will be upon Trophoblastic Disease, Vulvar Malignancies, and Endometriosis. Invited guests include Dr. John Lewis, New York, Dr. George Morley, Ann Arbor, Michigan, and Dr. Hugh Shingleton, Birmingham, Alabama.
 For Information: W. T. Creasman, M.D., Director, Gynecologic Oncology, Box 3079, Duke University Medical Center, Durham 27710

September 12-13

North Carolina Association of Blood Bankers Annual Convention
 Place: Sheraton Inn, Charlotte
 For Information: Roy A. Weaver, M.D., President, P. O. Box 2000, Cape Fear Valley Hospital, Fayetteville 28302

September 12-14

Legislative Workshop: this institute will bring together members of the North Carolina Medical Society and persons from the legislative and executive branches of North Carolina state government, so that North Carolina physicians may gain a better understanding of the process of government
 Place: Center for Continuing Education, Appalachian State University, Boone
 Sponsors: North Carolina Medical Society and Smith Kline & French Laboratories
 For Information: Stephen C. Morrisette, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 18-21

Invitational Assembly for Advanced Urology: Pediatric Urologic Problems
 Place: Pinehurst Hotel and Country Club, Pinehurst
 Fee: \$135
 Credit: 18 hours
 For Information: James F. Glenn, M.D., Division of Urology, Duke University Medical Center, Durham 27710

September 19

Child Abuse and Neglect Seminar

Credit: 6 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 22-26

Perceptual Motor Workshop

Place: Central Piedmont Community College, Charlotte

Sponsors: The Center for Human Development and the Charlotte Area Health Education Center

Program: The program "will make available the latest information on multi-disciplinary intervention in perceptual motor dysfunction."

For Information: Jeanne A. Palmer, Coordinator of Allied Health Education, Charlotte Area Health Education Center, P. O. Box 2554, Charlotte 28234

September 24-27

North Carolina Medical Society Annual Committee Conclave

Place: Mid-Pines Club, Southern Pines

Regular meetings will be scheduled for the chairman and members of almost all regular committees of the Medical Society. Committee members should plan to be present if at all possible.

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 25

"The Skin as a Mirror of Systemic Disease," Moore Memorial Hospital Continuing Education Series

Place: Country Club of Southern Pines (Elks Club)

Sponsor: Moore Memorial Hospital; UNC School of Medicine
Fee: \$11.50

Credit: 2 hours; AMA Category I & AAFP approved.

For Information: C. H. Steffee, M.D., P. O. Box 3000, Pinehurst 28374

September 25-27

Fifth Annual Seminar in Medicine

Fee: \$100

Credit: 15 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital
Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists Annual Conference

Place: Benton Convention Center, Winston-Salem

Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education, scientific exhibits and a display of commercial equipment.

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 9-12

4th Annual Conference on Medicine and Ministry of the Whole Person

Place: Lake Junaluska Assembly

Sponsor: The Conference on Medicine and Ministry of the Whole Person

Fee: \$75; couple \$125

For Information: Norman Boyer, M.D., Box 88, Tryon 28782

October 10

26th Annual Winston-Salem Heart Symposium

Place: Babcock Auditorium, Bowman Gray School of Medicine

Fee: Physicians \$20; nurses \$10

Credit: 6 hours; AAFP approved

For Information: Mrs. Betty Cauthen, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103



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Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



October 17-18

Seventh Annual Duke Symposium on Orofacial Anomalies
Credit: 12 hours; AAFP credit applied for
For Information: Raymond Massengill, M.D., Department of Surgery, P. O. Box 3523, Duke University Medical Center, Durham 27710

October 17-18

Office Management of Marital and Sexual Problems
Fee: \$100 (includes spouse)
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 24

"Priorities in the Treatment of Patients with Multiple Injuries."
Moore Memorial Hospital Continuing Education Series
Place: Country Club of Southern Pines (Elks Club)
Sponsor: Moore Memorial Hospital; UNC School of Medicine
Fee: \$11.50
Credit: 2 hours; AMA Category I & AAFP approved
For Information: C. H. Steffee, M.D., P. O. Box 3000, Pinehurst, 28374

October 30

Diagnosis and Treatment of Sleep Disorders
Credit: 2 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 3-7

Current Concepts in Pediatric Radiology
Place: Pinehurst Hotel, Pinehurst
Program: There will be a systems oriented format covering cardiopulmonary diseases on Monday, gastro-intestinal diseases on Tuesday, genito-urinary diseases on Wednesday and musculoskeletal diseases on Thursday, "with Friday left for miscellaneous disorders."
Credit: 25 hours
For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham 27710

November 7

Scientific Session, Alumni Association, Bowman Gray School of Medicine
Credit: 5 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 21-22

Second Annual Arthritis Symposium
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 5-6

Endoscopy Workshop
Place: Berryhill Hall
Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine
Fee: \$75
For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

December 5-6

Family Practice Workshops
Credit: Credit hours have not yet been determined
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient
Fee: \$100
Credit: 15 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 11

Wingate M. Johnson Memorial Lecture
Place & time: Babcock Auditorium, 11 a.m.
Speaker: Dr. Grant Liddle, Professor and Chairman, Department of Medicine, Vanderbilt University School of Medicine
Credit: 2 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

ITEMS OF SPECIAL INTEREST

October 4-7

Southern Psychiatric Association Annual Meeting
Place: Houston Oaks, Houston, Texas
For Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

November 3-8

Course in Laryngology and Bronchoesophagology
Program: Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.
For Information: Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association
Place: Miami Beach, Florida
For Information: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205

PROGRAMS IN CONTIGUOUS STATES

August 21-23

Three Days of Cardiology
Place: Hilton Head Inn, Hilton Head Island, S. C.
Sponsors: South Carolina Heart Association; North Carolina Heart Association; American Heart Association; Duke University Division of Cardiology.
Fee: Fellows, Associate Fellows and Members of the Council on Clinical Cardiology, \$100; non-members \$150
Credit: 10½ hours; AMA Category I; AAFP approved
For Information: George E. Stewart, Jr., American Heart Association, 44 East 23rd Street, New York, NY 10010

September 7-13

General Practice Review Course
Place: Mills Hyatt House Hotel, Charleston, South Carolina
Fee: \$150
Credit: 3½ hours AAFP credit
For Information: Dr. Vince Moseley, Director, Division of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S. C. 29401

September 8-12

The Nursing Management of Hypertension Workshop
Fee: \$100; Out-of-State applicants \$150
For Information: Ms. Marva Peek, Hypertension Program, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Georgia 30303

September 24-26

The Practical Application of Recent Surgical Advances
Place: Richmond Hyatt House, West Broad Street Road at Interstate 64, Richmond, Virginia
Sponsors: The Department of Surgery, in cooperation with the Department of Continuing Education
Fee: First half day \$60; registration limited to first 60 paid registrants who also will attend the course on Thursday and Friday. Fee for 2nd and 3rd days, \$125; registration limited to 150. Visiting interns and residents \$15; preregistration required.
Credit: 18 hours; AMA Category I; AAFP approved
For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

October 16-17

The 47th Annual McGuire Lecture Series—a Postgraduate Course in Common Problems in Dermatology
Sponsors: Department of Continuing Education and Department of Dermatology

Fee: \$95

Credit: 10 3/4 hours: AMA Category 1; AAFP credit applied for
For Information: Department of Continuing Education, School of
Medicine, Medical College of Virginia, Box 91, MCV Station,
Richmond, Virginia 23298

October 20-21

Tennessee Valley Medical Assembly annual meeting
For Information: Clifton R. Cleaveland, M.D., Tennessee Valley
Medical Assembly, Whitehall Medical Center, 960 E. Third
Street, Chattanooga, Tennessee 37403

December 7-10

Structure-Function Correlations in Cardiovascular Disease
Place: Williamsburg Conference Center, Williamsburg, Virginia
For Information: Miss Mary Anne McInerney, Director, Depart-
ment of Continuing Education Programs, American College of
Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN?
WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of
the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

From the Idea Exchange at the Auxiliary to the American Medical Association national convention in Atlantic City in June comes a lecture series, sponsored by the Auxiliary of the New Haven County Medical Association in Connecticut. The series is a relatively easy production for any county auxiliary and it clarifies for every doctor's wife the very real and threatening problems which are facing the medical profession — problems which obviously affect the families of the profession.

In view of this fact the New Haven Auxiliary questioned whether auxiliaries should "continue their traditional programs when their husbands' lives and careers, the wives' life-styles and childrens' futures are on the line?"

Lecture I was entitled "The Health Care Foundation—One Viable Alternative." A foundation was defined, discussed and contrasted to the Health Maintenance Organization (HMO).

Lecture II was "Current Medical Legislation—A Critical Evaluation." Various national legislative proposals were discussed and their political implications and the roles of wives and legislations emphasized.

Lecture III addressed "PSRO, HMO, CMI—An Alphabet Soup of Medical Change." PSRO (Professional Standards Review Organization) is something which you must understand. The question is whether you realize its relationship to federal control. Do you believe doctors can effectively implement the PSRO law?

Lecture IV was "Is Your Husband Ready for Professional Re-certification?" Can he pass his boards again? Are you ready for him to go back to school?

Lecture V was "Let's Do Something About Our Public Relations." Does your husband deserve his bad press? Who controls the doctors' public relations?

Lecture VI was entitled, "Now You Have The Right To Ask." A three-man panel of leaders in medicine answered questions. Many pertained to topics in the series; others delved into other medically oriented matters troubling wives of physicians.

The New Haven County Auxiliary made use of the excellent talent within their county Medical Society to put this lecture series across. They felt that this program attracted doctors' wives not previously interested in the auxiliary, thus stimulating members by informing and educating. The group emphasized the need for knowledgeable and articulate speakers if the program were to be effectively implemented.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

"How to Help the Chronic Alcoholic," a scientific exhibit prepared by Dr. John A. Ewing, director of the Center for Alcohol Studies at the University of North Carolina at Chapel Hill, won top honors at the annual meeting of the American Psychiatric Association in Anaheim, California, May 4-9.

The same exhibit also was awarded the highest honors at the American Industrial Health Conference in San Francisco in April.

The exhibit demonstrates how physicians and other health professionals may intervene successfully to assist with problems of alcoholism.

* * *

For the second time in three years, Dr. Christopher C. Fordham, III, dean of the UNC-Chapel Hill School of Medicine, has been named chairman of the Association of American Medical Colleges Southern Regional Deans.

* * *

Philip A. Bromberg has been appointed professor of medicine and chief of the Division of Pulmonary Diseases at the UNC School of Medicine.

He comes to Chapel Hill from the Ohio State University College of Medicine in Columbus, where he held a similar position.

Dr. Bromberg is chairman of the Food and Drug Administration (FDA) Pulmonary-Allergy Advisory Committee and a member of the policy and nominating committees of the National Tuberculosis and Respiratory Disease Association.

* * *

Dr. Timothy K. Gray, associate professor of medicine and pharmacology, UNC-Chapel Hill, has been awarded a \$50,000 March of Dimes clinical research grant for two years.

Dr. Gray will measure absorption of calcium and

phosphate under various conditions in the intestines of patients with familial hypophosphatemic rickets (FHR), an inherited disorder causing growth retardation, bone deformities and joint stiffness. The goal is to devise safer and more effective treatment than the therapy now being used for this condition.

* * *

New Appointments, UNC-Chapel Hill School of Medicine:

David Gordon Kaufmann, associate professor, Department of Pathology, holds the B.A. from Reed College and the M.D. and Ph.D. from Washington University. Since 1970 he has been a researcher for the Lung Cancer Branch of the National Cancer Institute and a surgeon with the U. S. Public Health Service.

David Hughes Walker, assistant professor, Department of Pathology, comes to Chapel Hill from Emory University School of Medicine, where he was a clinical assistant professor of pathology. He received his B.A. from Davidson College and his M.D. from Vanderbilt University.

David D. Schmidt, assistant professor in the Department of Family Medicine and clinical director of the Model Family Practice Unit, is a clinical instructor of pediatrics at Harvard Medical School. He is also preceptor of the Harvard Family Health Care Program

and maintains a private practice in Amesbury, Mass. His A.B. and B.M.S. are from Dartmouth College and Medical School respectively. His M.D. is from Harvard Medical School.

Stanley G. Kleiner, adjunct assistant professor in the Department of Family Medicine and associate director of the Rural Community Practice Models Program, was a senior consultant of Family Health Care, Inc., in Washington, D. C. His doctor of pharmacy is from the University of California Medical Center and his M.P.H. from Harvard University.

* * *

Promotions

To associate professor: James D. Folds, bacteriology and immunology; Lorcan A. O'Tuama and Evin H. Sides, III, medicine; William L. Saylor, radiology; Charles P. Schuch, physical therapy; Peter J. Starek, surgery; and Catherine A. Taylor, psychiatry, pediatrics and family medicine.

To assistant professor: Frederick P. Avis, surgery, bacteriology and immunology.

* * *

The University of North Carolina School of Pharmacy at Chapel Hill has been awarded two grants.

Dr. Kuo-Hsiung Lee received a three-year \$75,000 grant from the National Cancer Institute for natural



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products research in the area of plant antitumor agents. Lee is an associate professor in the Division of Medicinal Chemistry.

The Medicinal Chemistry Training grant was renewed for \$14,933 by the U. S. Public Health Service to support predoctoral candidates in medical chemistry. Dr. Claude Piantadosi directs the program.

* * *

The U. S. Patent Office in Washington has issued a patent for the Hulka Clip and Applicator. The Hulka Clip is a tiny plastic and stainless steel device designed to prevent pregnancy.

Dr. J. F. Hulka, for whom the clip is named, is a member of the faculty at UNC-Chapel Hill. Dr. Hulka developed the clip with the technical assistance of a Chicago engineer, George Clemons.

The Hulka Clip makes possible safe female sterilization on an outpatient basis. The clip is the culmination of seven years of basic, animal and clinical research.

Dr. Hulka conducted much of his research at UNC-Chapel Hill where he is a member of the teaching faculty in the School of Medicine's Department of Obstetrics and Gynecology and the School of Public Health's Department of Maternal and Child Health.

* * *

Dr. George Johnson, Jr., chief of the division of vascular and traumatic surgery at UNC-Chapel Hill, recently delivered the presidential address at the fifth annual meeting of the University Association for Emergency Medical Service (UAEMS).

Dr. Johnson, Roscoe Bennett Gray Cowper Professor of Surgery, is the outgoing president of the association.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

A husband and wife physician team who are specialists in infectious diseases were invited to present a series of lectures in Lima, Peru, at the medical school in early July.

They were Dr. Samuel L. Katz, chairman of the Department of Pediatrics and chairman of the Committee on Infectious Diseases of the American Academy of Pediatrics, and Dr. Catherine Wilfert, also a pediatrician, who is head of the Diagnostic Virology Laboratory and the Duke Hospital Infections Committee.

* * *

On a trip to Japan over July 4, Dr. William G.

Anlyan had the opportunity to renew a friendship to Duke that dates from the turn of the century.

Anlyan, vice president for health affairs, was invited to give two lectures at an international symposium on medical education. The symposium chairman was Dr. Shigeaki Hinohara, whose father studied at Trinity College here in 1900 and became a prominent Methodist minister in Tokyo.

The son also has visited Duke and worked with the late Dr. Wilburt C. Davison, Duke's first dean of medicine, in establishing training programs for worthy young Japanese scholars.

* * *

Dr. Nicholas Georgiade, professor of plastic, maxillofacial and oral surgery, has been named to succeed Dr. Kenneth Pickrell as chief of the Division of Plastic and Maxillofacial Surgery.

Pickrell, who has been a member of the faculty and chief of the division since 1944, will remain at Duke as professor and will continue his activities in patient care, teaching and research.

Georgiade is vice president of the American Association of Plastic Surgeons and previously served three years as its secretary. He is a past president of the American Society of Maxillofacial Surgeons.

* * *

Chaplain Wes Aitken finds himself the star of an award-winning film strip produced by the Methodist Church. The strip, "What Is a Chaplain?" received the top award in audiovisual competition sponsored by the Religious Public Relations Council.

The major focus of the film is Aitken's role as hospital chaplain, a position he has held at Duke since 1956.

* * *

A young researcher here who has been credited with being the key member of the first group to produce antibodies to a specific communicable disease in the laboratory has received a \$19,000 grant from the Damon Runyon-Walter Winchell Cancer Fund of New York.

Dr. Jeffrey Jay Collins, assistant professor of experimental surgery and assistant professor of microbiology and immunology, was awarded the grant to continue his work in a study entitled, "In Vitro Synthesis of Monoclonal Antibody."

While a doctoral student in microbiology and molecular genetics at Harvard University in 1972, Collins succeeded in an experiment which may be a first step toward the large-scale manufacture of disease-stifling antibodies in the laboratory.

The researcher explained that he subjected spleen cells from a rabbit, which had previously been immunized with material from a pneumonia-causing bacteria, to a virus known as simian virus 40. This virus transformed some of the cells into a cancer-like state which continues to grow and continues to produce antibodies specific for the original pneumonia-causing bacteria.

News Notes from the—

**BOWMAN GRAY SCHOOL
OF MEDICINE
WAKE FOREST UNIVERSITY**

Bowman Gray has been awarded a \$51,679 grant from the Winston-Salem Foundation for the creation of a unit for the diagnosis and treatment of childhood infectious diseases of the respiratory system.

Plans for the unit include a clinic where children from throughout the region can be referred for care. It also will involve the acquisition of sophisticated laboratory equipment for better diagnosis of infectious respiratory diseases.

The new unit will be part of the medical school's Department of Pediatrics and will be directed by Dr. Doris S. Kelsey, associate professor of pediatrics.

* * *

Two grants from the Department of Health, Education and Welfare have been made to Bowman Gray to expand its breeding colonies of the types of monkeys which are most important to research on atherosclerosis and other cardiovascular diseases.

The two grants, totaling more than \$1.6 million, are from the National Heart and Lung Institute and the Division of Research Resources.

The \$1,111,861 grant from the heart and lung institute will be used to establish one of four national resource centers for the production of non-human primates. Major breeding colonies of patas monkeys, rhesus monkeys and stump-tail macaques will be developed.

The \$497,379 grant from the Division of Research Resources will support the expansion of the school's squirrel monkey breeding colony. Bowman Gray already has the largest breeding colony of squirrel monkeys in the United States.

The entire program will be conducted through the school's Specialized Center of Research (SCOR) on Arteriosclerosis, one of only 13 such centers in the nation.

The emphasis on the domestic production of monkeys for research has resulted from a recent trend toward limited exportation of monkeys by countries which previously have supplied them.

* * *

Fourteen people have been added to the full-time faculty of the Bowman Gray School of Medicine.

They are Dr. Frances G. Baird, instructor in pathology; Dr. Marshall R. Ball, instructor in radiology (neuroradiology); Dr. Donald L. Copeland, associate professor of family medicine; Dr. Carlene W. Elsner, instructor in obstetrics and gynecology; Dr. John I. Fishburne Jr., associate professor of obstetrics and gynecology and associate professor of anesthesiol-

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ogy; Dr. Gerald W. Friedland, professor of radiology (gastroenterology); and Dr. Howard D. Homesley, assistant professor of obstetrics and gynecology (oncology).

Also, Dr. Frederic R. Kahl, assistant professor of medicine (cardiology); Dr. Curtis L. Parker, assistant professor of anatomy; Dr. John F. Reidy, visiting assistant professor of radiology; Dr. Martin I. Resnick, instructor in urology; Dr. Sara H. Sinal, instructor in pediatrics; Barbara J. Still, instructor in pediatrics (psychology); and Dr. Richard L. Weaver, assistant professor of pediatrics.

* * *

Gary G. Fleming has joined the staff of the medical school and North Carolina Baptist Hospital as assistant director of development.

Fleming has 12 years experience in sales, marketing and personnel management. He is a native of Henderson and holds the B.S. degree from North Carolina State University.

* * *

Dr. William J. Simons has been named the first Bristol Fellow in Infectious Diseases at Bowman Gray.

He began special training in infectious diseases and immunology at Bowman Gray on July 1. He previously was a senior resident at North Carolina Memorial Hospital in Chapel Hill.

Bristol Laboratories initiated the fellowship program to support training for qualified candidates who intend to pursue careers in infectious diseases and immunology.

The Section of Infectious Diseases at Bowman Gray was awarded one of four fellowships given this year in the nation. The fellowships are awarded on a competitive basis, with the qualities of the candidate and the institution where he will receive his training being considered.

* * *

Dr. Clark E. Vincent, professor of sociology and chairman of the Department of Medical Social Sciences and Marital Health, has been named to a four-year term on the Social Problems Research Review Committee of the National Institute of Mental Health.

* * *

Dr. Eben Alexander Jr., professor of neurosurgery, has been appointed to represent neurosurgery on the Interspecialty Council of the American Medical Association.

* * *

Dr. Frederick W. Glass, assistant professor of surgery, has been elected a member of the Board of

Directors of the North Carolina Chapter of the American College of Emergency Physicians.

* * *

Dr. C. Douglas Maynard, professor of radiology, has been elected vice president-elect of the Society of Nuclear Medicine.

* * *

Dr. James G. McCormick, associate professor of otolaryngology, has been elected to a three-year term as a councillor on the Executive Board of the Society of Neuroscience, North Carolina Chapter.

* * *

Dr. Robert W. Prichard, professor and chairman of the Department of Pathology, has been appointed to a four-year term as a member of the Primate Research Centers Advisory Committee in the Division of Research Resources, National Institutes of Health.

* * *

Dr. Richard L. Witcofski, professor of radiology, has been elected a trustee of the Society of Nuclear Medicine and named editor of the society's "Audiovisual Programs."

American Academy of Facial Plastic and Reconstructive Surgery, Inc.

Dr. Carl N. Patterson, Durham, was installed as president of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. during the June meeting of the Academy's Second International Symposium on Plastic and Reconstructive Surgery of the Head and Neck. He succeeds Trent W. Smith, M.D., Columbus, Ohio, and will serve a term of one year. Richard C. Webster, M.D., Brookline, Mass., was chosen president-elect to take office in 1976.

Dr. Patterson is a staff member at McPherson Hospital and Clinic in Durham. He is an associate clinical professor of surgery (otolaryngology) at Duke University Medical Center, and clinical consultant in surgery at North Carolina Memorial Hospital. He is also on the consulting staff at Watts Hospital and Lincoln Hospital in Durham, Murdock and John Umstead Hospitals in Butner, and at Dorothea Dix Hospital in Raleigh.

The American Academy is an international medical society of more than 1,400 otolaryngologists and other specialists who perform head and neck plastic surgery. The International Symposium sponsored by the Academy is a multi-discipline conference designed for the exchange of information and presentation of advances by all those medical specialties active in head and neck plastic surgery, including ophthalmology, otolaryngology, plastic surgery, dermatology and maxillofacial surgery.

Month in Washington

The unusual one-day "public oversight" hearings of the House Ways and Means Committee's Health Subcommittee to determine if the Department of Health, Education and Welfare is superseding Congressional intent in an increasing number of Medicare cost-control regulations was marked throughout by angry confrontation between the HEW Secretary and health providers.

Undaunted by a solid array of heated opposition from medical and hospital groups, Secretary Caspar Weinberger told the Subcommittee that the four disputed Medicare regulations will save about \$250 million a year and "improve the quality of care."

The hearing bringing together Weinberger and his critics was called by Subcommittee Chairman Dan Rostenkowski (D-Ill.) who said he was sorry the confrontation had to take place. "I hope the Subcommittee can remove roadblocks. We should really try to get the government and the health care industry out of the courtroom and into the conference room where the debate belongs."

Four lawsuits have been filed against the HEW Department to overturn the regulations. Members of hospital and physicians' groups, including the American Medical Association, urged the lawmakers at the hearing to crack down on HEW for going beyond the intent of law. But there was little indication from the Subcommittee that any swift action is contemplated.

Weinberger, easily fielding most of the Subcommittee's questions, refused to acknowledge any merit in the private sector's slashing attacks on the regulations, insisting the regulations followed the intent of Congress and were needed to curb costs. He suggested the remedy would be in seeking to have Congress change the laws, rather than in suing HEW.

The regulations under fire:

- * Social Security's Utilization Review (UR) final regulations requiring elaborate institutional post admission review mechanisms.
- * Reducing the schedule of limits on hospital inpatient general routine service costs from the 90th to the 80th percentile.
- * Limitation on recognition of physicians' prevailing charge increases, based on an economic index.
- * Termination of the inpatient routine nursing salary cost differential.

Stressing a common theme among the witnesses, the AMA cited "a general feeling of futility concerning administrative action felt by the public as a whole, but

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Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above WARNINGS about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fetal bone growth rate observed in premature infants given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms), anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above. (See WARNINGS)

Renal toxicity: rise in BUN, apparently dose related. (See WARNINGS)

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of renal glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin[®] (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q 12 h for a total of 5.4 grams.

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Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see WARNINGS), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

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especially by groups subject to and particularly affected by federal regulation." Ernest T. Livingstone, M.D., Chairman of the AMA Council on Legislation, said many professional associates display "an attitude often of exasperation, consternation and indignation with respect to the bureaucratic administration of government programs.

"Administrative regulations," Dr. Livingstone said, "often expand upon or subvert the intent of Congress." This is why, he explained, the AMA for the first time in its history recently sued the HEW Department over the UR regulations. Federal Judge Julius Hoffman upheld the AMA's contentions and issued a restraining order against carrying out the UR rules. The HEW Department has recommended that the case be appealed.

A key AMA argument was that admission review within 24 hours is directed almost solely to protect hospitals against possible non-reimbursement—not the patient's health. Judge Hoffman said that if "patients who cannot pay cannot be hospitalized when diagnosis is unclear, the potential injury to the patient's health may be irreparable."

Edgar T. Beddingfield, M.D., Vice Chairman of the AMA Council on Legislation, said HEW barged ahead on the physicians' Medicare fee index without giving interested parties a chance to question the details of the regulations. There is no justification in either the law or its legislative history for imposition of a national economic index, Dr. Beddingfield told the panel, noting that Medicare fee recognition "has long lagged behind current trends in physicians' fees." Because of the unique two-year delay, he said, the index limitations could result in shifting the financial burden to Medicare-Medicaid patients by driving reimbursement further below realistic fees.

Also criticizing the Medicare fee constraints, John Alexander McMahon, President of the American Hospital Association, said "this unilateral arbitrariness is precisely the problem with the general approach to program economic controls adopted by the Social Security Administration in carrying out its responsibilities. It clearly suggests that SSA continues to utilize law to suit its own concerns and not to reflect in a careful and publicly acknowledged way a commitment to honor legitimate costs in the delivery of health care."

* * *

The physicians' Medicare fee index angrily debated by the AMA and the HEW Secretary during the Ways and Means Health Subcommittee "public oversight" hearing, limits reimbursement to 17.9 percent above levels prevailing in fiscal year 1973.

Now in effect, the new payment formula, according to HEW Secretary Weinberger, will save the government an estimated \$26 million during this fiscal year out of a total Medicare Part B outlay of \$3.2 billion.

Most of the objections to the national formula which is pegged to various cost-of-living indexes were

brushed aside by HEW and Social Security in issuing the regulations in final form.

The AMA has charged that Congress intended local rather than national indexes; that the limitation was not supposed to be on a procedure-by-procedure basis but an aggregate; and that HEW allowed insufficient time for discussion on the manner in which it has decided to draw up the index. The control will simply force more physicians to abandon the assignment method, AMA warned.

Weinberger argued that while the Senate Finance Committee report suggested that a separate index for each locality be calculated, "a national index is being used, at least initially, because the data required to construct local indices are not now available."

The index will be applied to every prevailing charge in each locality. It will also be applied on a cumulative basis with fiscal 1973 serving as the base year. Increases in prevailing charges over the 1973 base year level cannot exceed the rate justified by the economic index calculated for that period.

Any individual prevailing charge that would increase by more than 17.9 percent over the 1973 base level will have its rate of increase limited to 17.9 percent. Prevailing charges that have increased by less than 17.9 percent will be unaffected. Any portion of the allowable increase not used will be carried forward to future years.

Because physicians are incorporating in increasing numbers, Internal Revenue Service data are no longer a good source of information about changes in physicians' office practice expenses, Weinberger said. Pertinent components of the Consumer Price Index, the Wholesale Price Index, Bureau of Labor Statistics wage indices and data from Medical Economics were used instead.

* * *

F. David Mathews, 39-year-old President of the University of Alabama, has been selected by President Ford to be the new Secretary of the Health, Education and Welfare Department.

Incumbent Secretary Caspar Weinberger has said repeatedly in recent months he wished to return to California. He was not ousted from the post. His resignation is effective August 10, 1975.

Mathews is supposed to be more liberal than Weinberger whose chief forte was economy and rigid controls to effect economy. Completely unknown on the national political scene, the youthful University President has described himself as an independent. Rumor has it that he is at odds with Alabama Governor George Wallace.

A Phi Beta Kappa graduate of the University of Alabama, Mathews holds a Ph.D. in history from Columbia University. He has been with the state university since receiving his doctorate.

Whatever Mathews' other qualifications, the White House obviously had some 1976 political considerations in mind in tapping the southerner from Wallace's state.

The Senate must confirm Mathews for the post, but no troubles are seen.

As HEW Secretary, Mathews will be at the center of domestic controversies, including welfare, social security, education and the big federal health programs. He will spearhead the Ford Administration's expected drive for its own national health insurance program next year. He will also have to cope with the lawsuits filed by medical and hospital organizations against control regulations imposed by Weinberger. And there's always the vexing and apparently insoluble problem of straightening out the organizational mess at HEW.

* * *

The Association of American Medical Colleges (AAMC) has filed suit to prevent the Department of Health, Education and Welfare from implementing the Medicare-Medicaid hospital cost-control regulations which became effective July 1, 1975.

The action seeks a preliminary injunction against regulations which set limits on routine service costs in short-term, non-federal hospitals.

AAMC says the regulations fail to consider factors in hospital-cost measurement that Congress wrote into law; namely, the scope of services offered, the quality and intensity of care and hospitals' educational programs. As a result, many hospitals' daily costs will soar far beyond the amounts allowed, AAMC says.

HEW's reimbursement schedule for these routine daily costs groups hospitals according to their urban or non-urban location, area per-capita income and bed number. Similar interim regulations have been in effect for the past year, but at a higher reimbursement rate.

"If these new regulations are allowed to stand, Medicare patients could lose up to \$68 million worth of hospital services next year," said John A. D. Cooper, M.D., President of AAMC.

Medicaid charges also will be affected, he points out, since by law, Medicaid hospital charges cannot exceed those of Medicare. Other third-party payers are likely to use the new schedules in setting payment rates, he added.

"The new ceilings for payments will work a tremendous hardship on U. S. hospitals," he said. "More importantly, they will, for the first time since Medicare began, place many Medicare patients in jeopardy of having to pay for a portion of their hospital costs."

Particularly hard hit would be the nation's teaching hospitals, said Charles Wolman, Administrator of Yale-New Haven Hospital, New Haven, Connecticut. AAMC estimates 733 hospitals, about 12.8 percent of the total, would be adversely affected.

"Johns Hopkins University Hospital, in Baltimore, would have a maximum (for daily routine charges) of \$120," he said, "while D. C. General Hospital, 34 miles away, would be allowed \$174.

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"Duke University Hospital (in Durham, N. C.) would be allowed \$89 while nearby Charlotte, N. C., Memorial Hospital would receive \$120."

Wolman's own hospital, Yale-New Haven, has been allotted a daily allowable charge of \$174.

"Duke suffers, for instance, because of a low per-capita income level in its area. Duke's costs are probably 10-15 percent less than ours, due to lower labor costs," said Wolman, "but they certainly are far more than half as much."

Interim regulations have been in effect for the past

year which set Medicare daily hospital charges at the 90th percentile of the national total. The new regulations lower this to the 80th percentile.

"The interim regulations . . . have many of the serious faults of the new regulations," said Dr. Cooper. "We decided to live with them for a year, and not take legal action earlier, because the Secretary promised in a press release June 6, 1974, that the revisions would incorporate criteria which would make them less arbitrary and capricious. It is obvious that he has not kept his promise, and our only recourse is in the courts."

Book Reviews

Psychiatry in Primary Care. By Remi J. Cadoret, M.D. and Lucy J. King, M.D. 339 pages. Price, \$12.95. St. Louis: C. V. Mosby Co., 1974.

The authors of this book have recognized an important need in primary care medical practice. They attempt to present the diagnostic and management principles of outpatient psychiatry in a manner which should be useful for the non-psychiatrist primary care physician. They have resurrected the "medical model syndrome" approach to psychiatric diagnosis and treatment. Diagnosis is organized according to the old and abiding concept in medicine: The syndrome, a recognizable group of signs and symptoms. Inferences as to motivation and etiology (except in organic brain syndromes) do not enter into this system of diagnosis. Treatment is eclectic, and its nature is determined by the syndrome diagnosis and by a common sense, empirical approach based upon adequately designed clinical studies and the clinical experience of the authors. They claim that this psychiatric view can be characterized as data-oriented, with empirical observations the foundation of both the definition of syndromes and the delineation of effective treatment. This approach is calculated to obviate the "psychiatric mystique."

This approach is in marked contrast to that of much present-day psychiatry, with its emphasis on the hypothetical and conjectural aspects of conscious and unconscious motivations, social or environmental events that have presumably resulted in emotional disturbance, symptoms and suffering in the patient. Preoccupation with causal factors, while admirable and perhaps of heuristic value, may have led to a complexity of explanation and vocabulary which the

non-psychiatrist physician finds difficult to appreciate as clinically applicable in his busy medical practice. To participate in the search for the etiologic roots of disturbance requires expertise in some theoretical dynamic scheme, and the training needed to acquire such a skill can be formidable.

The authors avoid hypothesis and conjecture about causation, believing that knowing the cause is not essential to diagnosis and treatment. They point out that effective treatment and management of illness syndromes have often been empirically worked out before a cause was known, and emphasize that there are few proved causes of psychiatric conditions but a plethora of hypotheses about causes, most of which have little, if any, clinical relevance for practical application by the primary care physician.

Most practicing physicians, particularly primary care physicians, have recognized the prominence of psychiatric conditions in their patients. The need for diagnostic and management skills to provide effectively comprehensive health care demands attention to the principles of outpatient psychiatry. It is believed that basic psychiatry can be made more accessible and understandable to those trained in a "medical model" if the syndrome approach, as presented in this book, is incorporated into a comprehensive approach to the whole patient and his environment.

This publication, designed for the primary care physician, should help in assuring that family practice residents and those in other primary care specialties achieve competence in identifying and managing ambulatory psychiatric problems prior to their entry into practice. It should also serve as a valuable resource to

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WILLIAM S. PEARSON, M.D.

Stroke and Its Rehabilitation. By Sidney Licht, M.D. (ed.) 562 pages. Price, \$20.00. Baltimore: Waverly Press, Inc., 1975.

This comprehensive book encompasses nearly every aspect of stroke rehabilitation. The editor has assembled sixteen authorities in compiling the text.

The first 180 pages provide a setting for the book's primary intent, that of rehabilitating the patient who has suffered the consequences of a major cerebrovascular accident. In these initial chapters, there are brief glimpses at subjects that comprise many textbooks of neurology. Presented in capsule form is the natural history, pathology, physical examination, diagnosis and treatment of stroke, including medical and surgical approaches.

Later chapters are devoted to specific rehabilitative

techniques, including a discussion of the use of neurophysiologic therapy, a relatively novel concept. This principle applies activation of strategic muscle groups and inhibition of other muscle groups which would interfere with recovery of a paretic or spastic limb.

Other topics expounded in great detail include speech training, mental and social problems related to rehabilitation of hemiplegics, and even a chapter describing types of wheelchairs available. There are ample references at the close of each section.

The book has a ten-page glossary of terms used in stroke literature, which should be helpful for the non-neurologist. The index is extensive and well done.

This reviewer doubts that stroke and its rehabilitation will provide much benefit for the physician outside neurology or rehabilitative medicine. The average practicing internist or general practitioner probably does not have the time for or interest in the detailed information. However, these comments are not to detract from this book's obvious excellence as a reference publication, and I recommend it for this purpose.

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NORTH CAROLINA

Medical Journal

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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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JOHN GLASSON, M.D.	306 S. Gregson St., Durham 27701
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DAVID G. WELTON, M.D.	3535 Randolph Road, Charlotte 28211
(December 31, 1977)	
EDGAR T. BEDDINGFIELD, JR., M.D.	Wilson Clinic, Wilson 27893
(December 31, 1977)	

Alternates to the American Medical Association

GEORGE G. GILBERT, M.D.	1 Doctor's Park, Asheville 28801
(December 31, 1976)	
LOUIS DE S. SHAFFNER, M.D.	Bowman Gray, Winston-Salem 27103
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(December 31, 1977)	

The University and the Community

W. Reece Berryhill, M.D.*

MEMBERS of the family of the late Joseph Ward Hooper, Sr., members of the New Hanover County Medical Society, and of the Robert A. Ross Society, ladies and gentlemen: I am extremely grateful for, but I hope you understand somewhat overcome by, the invitation to give the Ninth Joseph Ward Hooper, Sr. Memorial Lecture and particularly at the first "off the campus" meeting of the Robert Alexander Ross Society, of which I have been an honorary member since its birth.

I had the pleasure of knowing Dr. Joseph Ward Hooper, Sr. for a number of years. This came about chiefly because of his long association with the late Dr. George Johnson, Sr. with whom my friendship began in 1917 when I entered the university as a freshman and George Johnson was a second year medical student. I am aware of the many contributions Dr. Joseph Hooper made in his chosen field of clinical excellence, to Wilmington and to eastern North Carolina, but over and beyond that, he was a great

person in all respects and his helpfulness to individuals, both to his professional colleagues and to many citizens, are lasting ones.

After learning of some of the national and international leaders in the field of surgery who have been invited to give the Hooper Memorial Lecture, I must confess that I began to get a certain degree of cold feet despite this long, humid and hot summer and to a degree this still persists. When I saw that two former students of the University of North Carolina Medical School, Drs. George Rosemond and George Jordan, both friends of many years were in this list, I was additionally pleased to have received this invitation.

Now as you know, I am not a surgeon, although since the days as a medical student some of my closest friends have been in the field of surgery and these include a goodly number of those in Wilmington. Likewise, it is very interesting to me that of all the community hospitals with which the university medical school has and is developing educational relations, the New Hanover Hospital, through the interest and leadership of Dr. Lockert B. Mason, at that time the director of medical education, and with the support of the surgical

staff, was the first, and to date one of only two, in which, from the standpoint of the staff, surgeons initiated the steps to develop joint educational programs. This, too, may well be a heritage of Joseph Hooper, Sr. in his concern for the standards of surgical care in the community and in its hospital.

For many reasons, on this occasion it seemed appropriate to speak on the role of the university in the community—to present briefly the changing trends in medical education in the 1970s, the implications of these for the community hospitals of the state, and the *importance of this joint undertaking* in medical and health related education in improving the delivery and quality of health care in North Carolina, in the years ahead.

The distinguished philosopher, Alfred North Whitehead, in discussing the role of the university once wrote, "The task of the university is the creation of the future so far as rational thought and civilized modes of appreciation can affect the issue."¹

"There is little question that today's universities can scarcely anticipate the future if they do not confront the relevant questions of the present as intellectual, cultural and practical forces. In this endeavor,

The Joseph Ward Hooper, Sr., Memorial Lecture, read before the Annual Meeting of the Robert A. Ross Obstetrical-Gynecological Society, September 21, 1974.

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the medical school becomes one of the university's most potent tools in the transformation of man and society. To 'create the future' of health care, actively and imaginatively, the medical school must respond to the vectors of social and scientific progress before they make that future too painfully obvious."²

Historically, over the last 200 years or more, the education of physicians, and in some respects other professions as well, including especially the legal, has evolved through several stages. In general these can be briefly classified as follows: (1) The apprentice or preceptor system; (2) The proprietary professional schools; (3) The professional schools carrying the name of the university but without its support or control; (4) The era of university medical schools *in fact as well as in name*—a result of the recommendations of the Carnegie Foundation for the Advancement of Teaching study and report on medical education in 1910 (the famous "Flexner" Report); (5) The biomedical research era—roughly beginning in the mid-1950s—climaxing in late 1960s and continuing at a somewhat slower pace until the present; and (6) The community medicine era of the medical schools.

The community involvement of medical schools in education at all levels—and on various fronts, and in research and studies relating to the area of health as patient care may be affected—really began in the mid-1960s. Understandably for many reasons, the pace was slow at first. But these commitments and activities in the past four to five years have increased substantially. This is not to say that for more than two centuries since the University of Pennsylvania School of Medicine began operation in 1765, medical schools have not had teaching services in one way or another in public or private hospitals which were in the vicinity of the school—or that the faculty of medical schools have not been a valuable part of, have not visited, given lectures, or held clinics in community hospitals, by invitation, or as a part of their responsibilities. In the present context, however, there is necessarily

implied a more meaningful relationship between the hospital and its community—and the university medical center.

The primary reasons for this present development are: (1) An increasing awareness of the need to educate more medical and health related personnel, far more than most university medical centers can adequately care for, within their own hospital facilities; (2) The realization that there are many able teachers in the community hospitals, whose inpatient wards and outpatient departments become essential to the desired goal of producing a necessary increase in health manpower; (3) The need, in this era of increasing specialization in university hospitals, of broadening the base of the educational experiences of undergraduate and graduate medical students by providing contacts with more realistic varieties of human illness seen in the community hospitals, and, with this, the beneficial experience of contacts with physicians who emphasize the *care of the sick individual* versus the all too frequently emphasized *sick organ approach* of many in the university medical centers; (4) The foresight at first of a few medical school faculty and administrators and community leaders, both lay and medical, of the joint benefits of such undertakings; (5) Very importantly, for the present and the future, an increasing interest in and concern for the delivery of medical care outside the university medical centers and in the communities by: (a.) The younger medical faculty members; (b.) The house staff (interns, residents, and fellows in training at the university medical centers); (c.) Especially in more recent years by the medical students of the allied health professions; (d.) Fortunately, also by an increasing number of department chairmen in the clinical departments of medical schools; (e.) As a result of these factors, plus one additional very practical development, reduced federal funds supporting research, and the increased availability of federal support for community hospital programs to increase health personnel and improve the availability

of medical care of quality—both state and privately supported university medical schools have become increasingly involved in community hospitals or medical care in the communities in many geographical areas of the country.

It is pertinent that Dr. David E. Rogers, formerly professor and chairman of medicine at Vanderbilt University Medical School, dean of the Johns Hopkins School of Medicine and now the director of the Robert Johnson Foundation, said in an address in 1970: "However, I believe medical teaching centers must agree to employ their talents in new experiments in the delivery of health care and must recognize this as an appropriate area of inquiry for a modern university. I believe universities must begin to *develop out of hospital units* for experimenting with new ways of giving primary care and new ways of orienting students and house officers about such problems. I believe we must assume responsibilities for training new kinds of health professionals to extend physician effectiveness."³

Obviously there are different objectives among the university medical schools in joint programs with the community hospitals of different sizes and areas. But among these objectives are: (1) Providing opportunities for continuing education for the practicing physicians and other health-related professions centered in and around the community hospitals; (2) The education of increasing number of various categories of health personnel; (3) Enabling the medical schools to enroll and educate more medical students—perhaps more economically and certainly more effectively, and comprehensively in terms of future health care—through utilizing space, patients, and able physicians in private practice as members of their faculty in the community hospitals and, importantly, to educate the students more adequately for the needs of the community through these experiences in the community hospitals, in small towns, and rural health clinics to complement the more specialized training and environment in university medical cen-

ters; and (4) Likewise, such experiences are valuable in the education of the house staff and the full time medical school faculty in the problems of continuing care of patients in the communities.

The increasing magnitude of the problems facing higher education in this land provided the incentive for the Carnegie Corporation and the Carnegie Foundation for the Advancement of Teaching to finance a study by a very able group, known as the Carnegie Commission on Higher Education, in the late 1960s. This commission was chaired by Dr. Clark Kerr, former chancellor of the University of California system. The recommendations of this second study sponsored and financed by the Carnegie Corporation and the Carnegie Foundation for the Advancement of Teaching, if fully implemented, may have as profound an effect upon medical education and medical care as the first, 60 years earlier.

Because of the national concern for educating more medical and health personnel and the urgent need to achieve a more adequate supply and distribution of health manpower—especially in the more rural areas and the underserved sections of metropolitan areas—the *problems and opportunities* of the *health science schools* of universities were given high priority in this study. As a result, the first section of the Carnegie Commission report, "Higher Education and the Nation's Health," was published in 1970. Among the major recommendations for accomplishment of the above important objectives was the establishment of 126 Area Health Education Centers in the United States to serve localities removed some distance from a Health Science Center (a university center with a medical school and one or more other health professional schools).

The following is a pertinent paragraph from this report:

*Area Health Education Centers
(Regional Medical Education Centers)*

We recommend 126 Area Health Education Centers to serve localities without a

health science center. Each of these centers would be at a local hospital. The centers' educational programs would be administered by university health science centers. They would train medical students and doctor of dentistry candidates on a rotational basis; they would carry on continuing education for local doctors, dentists and other health care personnel; they would advise with local health authorities of hospitals; they would assist community colleges and comprehensive colleges in training allied health personnel; and, in other ways, they would help improve health care in their areas. We consider this development of basic importance.⁴

The Congress, in its own wisdom, in 1971 began to implement some of the general recommendations of this special report (policies for medical and dental education) and made further progress in 1972, specifically, in providing guidelines and funding for the first Area Health Education Centers for the nation, with grants to assist *eleven university medical centers* (health science centers) to establish *such centers in those states in which the university had primary responsibilities*. Interestingly, for North Carolina the commission's report recommended *three such centers—Wilmington, Charlotte, and Asheville*. It is undoubtedly of considerable importance in the success of the university medical school's application that, at the time of the Carnegie Commission's study, the University of North Carolina had already established educational relations with the New Hanover Memorial Hospital in Wilmington, the Charlotte Memorial Hospital, the Moses Cone Hospital in Greensboro, the Wake Memorial Hospital in Raleigh, and a consortium composed of the four hospitals in Area L (Nash General, Edgecombe General, Wilson Memorial, and Halifax Memorial Hospitals) to initiate some of the educational activities proposed by the study.

As defined by the Bureau of Health Manpower Education (National Institutes of Health) which has responsibility for carrying out Section 774A of the Comprehensive Health Manpower Training Act of 1971, an Area Health Education Center is a public or nonprofit hospital or a consortium of hospitals some distance from a university Health Science Center.

To meet the general objective of a better distribution of health personnel, an Area Health Education Center, as a joint partner with a university Health Science Center, must be willing to undertake the following specific programs: (1) The training of medical students, interns, and residents and continuing education for physicians with emphasis on primary care physicians; (general internists, pediatricians, family physicians, and obstetricians and gynecologists); (2) The undergraduate, graduate, and continuing education of nurses, dentists, pharmacists, and public health workers; (3) The specific development of training programs for allied health workers in the area, for example, family nurse practitioners, operating room nurses, physical and occupational therapists, and other allied health workers; and (4) The Area Health Education Center (the community hospital) must also undertake responsibility for providing health manpower support to the smaller community hospitals in the area and those hospitals must agree to assist the individual health practitioner in the designated area. (For example, as students, *undergraduate and graduate*, from the University of North Carolina receive part of their education in Wilmington, the New Hanover Memorial Hospital and its staff are expected to provide manpower assistance to the smaller hospitals in their area, both as a regional referral center for the more complex medical problems and to aid in the improvement of continuing education and medical care in those hospitals.)

Unquestionably, the fact that the UNC School of Medicine made a commitment to develop such programs in 1966 as a joint effort with community hospitals and provision

of modest financial support by the North Carolina General Assembly in 1969, made it possible for UNC to receive the largest single contract from the federal program when the awards were made at the end of a keen national competition on September 30, 1972.

To date we can report the following progress: For the past six years a part of the UNC medical student's education, as well as that of some of its residents, has been in community hospitals. This number is increasing every year and will continue at a faster rate in the years ahead with the increasing class size and the expanding family practice residency programs. In the academic year 1972-73 there were 301 medical student rotations in the community hospitals and 60 resident rotations.

THE PROBLEMS

Obviously it would be most unrealistic to imagine that such joint educational ventures would not create problems which likewise cannot be satisfactorily solved without the joint understanding and efforts of all concerned.

(1) One of the first and most difficult problems has been *that of the cost to both the hospitals and the university*. Although the Division of Education and Research in Community Medical Care was established in 1966 with a very limited budget of university funds and a Regional Medical Program grant, the first state appropriation in support of these activities was not made until 1969. This has increased with each session of the General Assembly thereafter. In 1972 federal funding (\$8,500,000) for a five year period became available and the Area Health Education Centers were officially established. In 1974 the General Assembly, on the basis of the early achievements accomplished and the *opportunities* of the AHEC efforts at the New Hanover, Charlotte Memorial, Wake Memorial and Area L Hospitals seemed to offer, made a generous appropriation necessary for the improvement and enlargement of the programs for the hospitals involved, with the understanding that these centers

would be increased in number in order to provide more statewide coverage. This appropriation includes funds: (1) For the construction and equipment of educational facilities in the community hospitals, including outpatient space, library space, and offices for the full time clinical faculty, etc.; (2) For providing *reasonable compensation* for the teaching activities of the part-time staff; (3) A liberal provision for salaries and for other necessary expenses in increasing the number of residencies as a part of the Area Health Centers opportunity and responsibility for the education of more primary care physicians—and especially for the development of a greatly increased number of residencies for family physicians. As a result, additional Area Health Education Centers are being planned for Asheville, Greensboro, Fayetteville and the northwestern area of North Carolina under the direction of the Bowman Gray School of Medicine and the northeastern area of North Carolina centered at Greenville and the East Carolina University in cooperation with other hospitals in this area, making a total of nine. Currently the Duke University Medical School is interested in increasing the number of residencies for family practice through this program as a part of their effort with community hospitals. Obviously the continuation of increasing state financial support is essential. This will depend in the years ahead upon the achievements in the areas of meeting the health manpower needs, especially the supply of primary physicians through the residency programs in these Area Center hospitals and the degree that health care in the less populated areas can be improved.

(2) There have been, are, and will perhaps continue to be different concepts and understandings regarding the university's role in this relationship with the community hospital. Let me say that for more than four decades, since I returned to North Carolina, I have, in a sense, been on both sides of the fence, having been a staff member of a very good community hospital

and a member of the board of trustees of two such hospitals. I can understand fully some of the misgivings and the feelings, at times, of insecurity of some members of the staff of the community hospital in regard to these undertakings with the university. These relate to availability to beds for the admission of the staff member's patients, the effect of the participation of students and house staff on patient care, and finally, and perhaps most importantly, the fear of *university control of the policies of the cooperating institution*. I feel very strongly on several of these points and on these issues I believe speak for the University of North Carolina: (a.) That the creation of *exact replicas of the university medical center in the community hospitals must be avoided*, otherwise the value of the community hospital is greatly diminished in its educational potential and its patient care responsibility, for which it was created; (b.) That while the final responsibility for the standards and quality of education in the affiliated hospital must remain with the university, since education is the university's major responsibility, these ventures *from the very beginning of the planning stage must be and must always be a joint undertaking* in all areas between the two institutions, their respective professional staffs, administrators, and trustees. The university can be a part of the community, a partner if you will, but never a dictator. *It should "provide guidance but not governance."*³ (c.) That on such a community base, hopefully, the joint resources of the university and the community hospital will provide the leadership and the knowledge to develop new, different, and better methods of providing improved health care, including the objective appraisals and evaluations that are necessary.

(3) There is the persisting problem of recruitment of able personnel, both by the university and the community hospitals for teaching, for administrative positions including the very important post of directors of the Area Health Centers, and the full-time faculty in charge of the

teaching programs on the various services, as well as the liaison representatives of the university medical school to each area center. But progress is being made, at times, slowly.

The success of these programs will depend not only on the quality in terms of professional and educational competence of the staff of the community hospital but, just as importantly, upon the *attitude of the full time faculty in the community hospital and their ability to gain and hold the confidence and the respect of their professional colleagues*, who are part-time members of the clinical faculty. It has been repeatedly demonstrated in North Carolina and elsewhere that the strength and interested efforts of the professional staff, of the hospital administration, and its trustees, and of their corresponding associates in the university medical center are the determining factors in the degree of success of these programs.

In summary, this presentation is a review of the university's joint efforts with the community hospitals to implement methods of expanding education for an increased number of health personnel in all categories for the goal of improving health care throughout North Carolina. Once again these efforts demonstrate the relation of the university to the community as suggested by the late Dr. Edward Kidder Graham, one of the great presidents of the University of North Carolina, in his inaugural address in 1914 when he envisioned that the relation of the university to the community in education as similar to that "*of a vine and its branches*." This was perhaps a philosophical expression of what he considered the oneness of these joint undertakings. In 1974, 60 years later, Dr. Graham would very likely see this relationship, in continuing the simile, as two vines intermingling their efforts to jointly increase their production.

It is obvious that from the very shaky beginning—shaky on all fronts—of these efforts with the in-

auguration of the Division of Education and Research in Community Medical Care in 1966, much has been achieved or at least reasonably solid, stable and satisfactory foundations have been laid. For the long haul, upon these foundations much remains to be built.

Perhaps many of you read in the newspapers the report of the address by Dr. Clark Kerr, the chairman of the Carnegie Foundation Study Committee mentioned earlier, which recommended the creation of this university-community hospital educational development, at the recent meeting of the Southern governors: "North Carolina has done the most so far" in developing Area Health Education Centers. He also added, "We may now be building too many medical schools" and "we could run into a surplus of doctors in the 1980s."⁶ I would call your attention to: (1) The splendid report in the September 1974 issue of *Hospital Practice* on the Area Health Education Centers developed in North Carolina and an excellent editorial by Dr. Henry Uhl, director of the Area Health Education Center in Asheville; and (2) It is of special interest to some of us that essentially the same role in medical education and health care for the university as proposed in the Area Health Education Centers was recommended for North Carolina by the National Committee for the Medical School Study (Sanger Commission) in 1946:

"Medical education has passed through many stages and we may have arrived at the point where it should be related to practically all phases of medical care. The medical school might join with the hospitals of the state in the development of a teaching program which would result in equal emphasis upon medical education and medical care: (a.) As an essential element of such a program, there must be a graded hospital organization or network (small community hospital, district centers, and the medical school hospital center) which is integrated with

the medical school; (b.) In order to accomplish the complete integration of medical education and medical care, the medical school must play a principal role."⁸

The encouraging status of the present statewide program is the result of: (1) The interest and wise leadership within the various community hospitals—their leaders of the clinical services, hospital directors and boards of trustees; (2) The interest and concern of the university. The major developments have evolved since 1970 when my able successor, Glenn Wilson, joined the faculty as associate dean, Community Health Services, and as director of the Division of Education and Research in Community Medical Care. Those of you who have worked with him realize his extraordinary qualities of understanding, of imagination, and of sound leadership based on many years of experience in the fields of medical care and medical education. Importantly also he has stood firmly on the fundamental concept and principle that the university and the community are joint partners. (3) The increased financial support—federal and state—essential for implementation of the joint objectives of the individual institutions and of the university. These developments support, I believe, the statement by Gasset in his book "*The Mission of the University*": "The life of the people needs acutely to have the university participate—as the university—in its affairs."⁹

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Surveillance for Ampicillin-Resistant *Haemophilus Influenzae* Type b Strains in North Carolina

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THE recent appearance in the United States of type b *Haemophilus influenzae* clinically resistant to ampicillin has aroused concern about the continued efficacy of ampicillin in treating *H. influenzae* meningitis.¹⁻⁵ Double therapy with chloramphenicol and penicillin has been suggested for meningitis in those areas with known ampicillin-resistant *H. influenzae* type b and in places where laboratory support is inadequate.⁴

We tested 78 isolates of *H. influenzae* type b in Chapel Hill, North Carolina, for sensitivity to seven antibiotics (Table 1): 26 isolates from the cerebrospinal fluid or blood of children with clinical meningitis (23 collected in the years 1973-74); two adult respiratory isolates (1973-74); and 50 isolates from nasal washings of children who were well, had upper respiratory symptoms, or otitis media (collected from July, 1972, to April, 1974).

Sensitivity testing was performed in Mueller Hinton broth containing

5 percent Fildes reagent (Difco), dispensed in microtiter plates (Canalco, Rockville, Maryland). Several methods of obtaining a standard inoculum were investigated. Cells scraped from 18-hour chocolate agar plates and suspended to uniform optical density gave variable colony counts, as did overnight Mueller Hinton broth cul-

tures. Uniform inocula were obtained by suspending several colonies in 5 ml of Mueller Hinton broth containing 1 percent Supplement C (Difco), followed by 3 to 5 hours incubation on a rotary shaker at 37°C until turbidity reached 25 Klett units (590 nm filter). A value of 25 Klett units gave a range of 1.0-4.5 x 10⁸ c.f.u. (colony forming

TABLE 1
Susceptibility of 78 Type b *Haemophilus Influenzae* Isolates to Seven Antimicrobials^a

Antibiotics		Antibiotic Concentration (μg/ml)										No. of Strains Tested
		12	25	5	1	2	4	8	16	32	64	
Pen	MIC	1	25	34	16	1	1					78
	MBC	1	20	33	20	3	1					
Amp	MIC	13	41	24								78
	MBC	13	36	28	1							
Gen	MIC			19	43	9	7					78
	MBC			10	45	16	7					
Tet	MIC	1	2	44	28							75
Chl	MIC		1	23	51	1						76
Ery	MIC					7	38	28	4			77
Cep	MIC				1	1	15	38	19	4		78

^aAbbreviations: Pen.—penicillin, Amp—ampicillin, Gen—gentamicin, Tet.—tetracycline; Chl.—chloramphenicol, Ery—erythromycin, Cep—cephalothin. Numbers are isolates inhibited by each antibiotic concentration.

From the Departments of Medicine, Pediatrics, Bacteriology and Immunology and Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, North Carolina.

Reprint requests to Dr. Anderson, Department of Pediatrics.

units)/ml. The inoculum used in sensitivity testing was 10^4 c.f.u./0.1 ml. Each sample was tested in duplicate in the same microtiter tray. All antibiotic solutions were prepared fresh on the day of testing and twofold dilutions were made. The final volume in each microtiter well was 0.1 ml. Final antibiotic concentrations were 0.12 to 64 μ g/ml. After inoculation, trays were sealed and incubated in a humidified CO₂ incubator at 37°C. The minimal inhibitory concentration (MIC) was the lowest which prevented visible turbidity or button of organisms after 24 to 28 hours incubation. The minimal bactericidal concentration (MBC) was determined for three antibiotics by streaking loopfuls from wells showing no visible growth onto chocolate agar plates containing 1 percent Supplement C.

All isolates had MIC for ampicillin of ≤ 0.5 μ g/ml and MBC of ≤ 1.0 μ g/ml (Table 1). Penicillin was only slightly less effective, with most of the isolates having a MIC of < 1.0 μ g/ml and a MBC of ≤ 2 μ g/ml. Over 90 percent of the strains had MIC and MBC for gentamicin of 2 μ g/ml; all samples were sensitive to 4.0 μ g/ml. Cephalothin and erythromycin are relatively inactive. These values are in general agreement with earlier reports.⁶⁻⁸

Seventy-two of the 78 isolates

were also tested by classical (macro) tube dilution method for susceptibility to ampicillin. Inoculum was 10^5 c.f.u./ml in Mueller Hinton broth with 5 percent Fildes reagent. All isolates had MIC of 1 μ g/ml or less to ampicillin. In addition, 23 of the isolates from blood or cerebrospinal fluid were tested to the same seven drugs listed in Table 1 in agar plate dilution utilizing chocolate agar plus 1 percent Supplement C. Inoculum size of both 10^3 and 10^5 c.f.u./ml were used. MIC with the 10^3 c.f.u./ml inoculum were similar to those obtained by microtiter. However, the larger inoculum (10^5 c.f.u./ml) resulted in marked increases in MIC (≥ 16 fold) for ampicillin and penicillin. Similar problems with determining agar plate sensitivities with large inocula have been previously noted.⁹

Each of 78 isolates of *H. influenzae* type b was susceptible to penicillin, ampicillin, tetracycline and chloramphenicol. The data suggest continued clinical efficacy of ampicillin for *H. influenzae* type b strains in North Carolina but the appearance of ampicillin-resistant *H. influenzae* in other localities emphasizes the importance of continuing antibiotic susceptibility testing.

ADDENDUM

Captain William G. Taylor, M.C.,

Department of Pediatrics, Womack Army Hospital, Fort Bragg, North Carolina, has reported the isolation of two strains of ampicillin-resistant *H. influenzae* type b from two children hospitalized with clinical meningitis at Fort Bragg in January, 1975. Dr. Clyde Thornsberry, Center for Disease Control, Atlanta, Georgia, confirmed the resistance of these two strains and reported the minimal inhibitory concentrations at 16 μ g/ml and 128 μ g/ml. In addition, the *Medical Letter* 17:15, 1975, recommends that chloramphenicol be included in initial therapy of bacterial meningitis in children older than two months.

References

1. Haltalin KC, Smith JB. Reevaluation of ampicillin therapy for *Haemophilus influenzae* meningitis. *Amer J Dis Child* 122: 328-336, 1971.
2. Khan W, Ross S, Rodriguez W, Coutroni G, Saz A. *Haemophilus influenzae* type b resistant to ampicillin. *JAMA* 229: 298-301, 1974.
3. Mortality and Morbidity. Ampicillin-resistant *Haemophilus influenzae*. 23: 259, 1974.
4. Nelson JD (ed). Should ampicillin be abandoned for treatment of *Haemophilus influenzae* disease? *JAMA* 229: 322-324, 1974.
5. Tomeh MO, Starr SE, McGowan JE Jr, Terry P, Nahmias AJ. Ampicillin-resistant *Haemophilus influenzae* type b infection. *JAMA* 229: 295-297, 1974.
6. Sabath LD, Stumpf LL, Wallace SJ, Finland M. Susceptibility of *Diphtheria pneumoniae*, *Haemophilus influenzae*, and *Neisseria meningitidis* to 23 antibiotics. *Antimicrob Ag Chemother* 5: 53-56, 1970.
7. Gordon RC, Thompson TR, Stevens LI, Carlson WH. In vitro susceptibility of *Haemophilus influenzae* to eight antibiotics. *Antimicrob Ag Chemother* 6: 114-115, 1974.
8. Williams JD, Andrews J. Sensitivity of *Haemophilus influenzae* to antibiotics. *Brit Med J* 1: 134-137, 1974.
9. McLinn SE, Nelson JD, Haltalin KC. Antimicrobial susceptibility of *Haemophilus influenzae*. *Ped* 45: 827-838, 1970.

It would be difficult to say why the village of Oldfields should have been placed in the least attractive part of the township, if one were not somewhat familiar with the law of mind of country communities. The first settlers, being pious kindred of the Pilgrims, were mindful of the necessity of a meeting-house, and the place for it was chosen with reference to the convenience of most of the worshipers. Then the parson was given a parsonage and a tract of glebe land somewhere in the vicinity of his pulpit, and since this was the centre of social attraction, the blacksmith built his shop at the nearest cross-road. And when some enterprising citizen became possessed of an idea that there were traders enough toiling to and fro on the rough highways to the nearest larger village to make it worth his while to be an interceptor, the first step was taken toward a local centre of commerce, and the village was fairly begun.—*A Country Doctor*, Sarah Orne Jewett, 1884, p 117.

Prophylactic Antibiotics in Hysterectomy

J. Edwin Clement, M.D.

FOR several years it has been an established practice in many centers to use prophylactic antibiotics before hysterectomy. Diverse opinion about this procedure, the failure to standardize the definition of postoperative morbidity and concern about giving prophylactic antibiotics to healthy people have caused concern about the need to continue this practice. Of special concern have been three deaths^{1,2} following the use of intravenous sodium cephalothin (Keflin®) during anesthesia.

Antibiotics have been used to decrease morbidity, shorten hospital stay and reduce hospital cost. With these factors in mind, it seemed appropriate to review the hysterectomies done in a three-man practice within the past year.

METHOD

Three surgeons practicing gynecology in Greenville, North Carolina, had comparable attitudes toward indications, surgical technique, giving of blood, surgical approach, early discharge from the hospital and respect for antibiotics. However, they differed in that one member of the group did not use routine antibiotics, one used them routinely and the third did occasionally. The results of hysterectomies done with and without prophylactic antibiotics could be compared since the general surgical considerations were similar. While the study is retrospective, the findings seem significant. No attempt has been made to discuss the various causes of postoperative morbidity.

MATERIALS

One hundred forty-six consecutive hysterectomies performed during 1973 were reviewed.

Antibiotics were given as follows: either cefazolin sodium (Ancef®) (0.5 g) or sodium cephalothin (1 g) intravenously beginning in the recovery period and every four hours by drip infusion for 48 hours, followed by cephalexin monohydrate (Keflex®) (1 g/day) for 10 days. Patients sensitive to penicillin were given another broad spectrum antibiotic in a similar manner.

Since postoperative morbidity has not been satisfactorily defined, it was defined for this study as the standard obstetric postoperative morbidity: a temperature of 100.4° on any two consecutive postoperative days, except for the first postoperative day.

OBSERVATIONS

Figure 1 shows a marked differ-

Figure 1 Incidence of Fever and Length of Post-Operative Stay			
Vaginal Hysterectomy	Fever Yes		P.O. Stay (days)
Repair			
20 AB — yes	30%		6.2
16 AB — no	87%		7.7
		Diff	-1.5
No Repair			
20 AB — yes	24%		5.4
24 AB — no	50%		5.9
Total 80		Diff	-0.5
Abdominal Hysterectomy			
36 AB — yes	36%		5.9
30 AB — no	40%		5.8
Total 66		Diff	+0.1
Grand total 146			

Reprint requests to 1705 West Sixth Street, Greenville, North Carolina 27834

Figure 2
Cost Analysis

Antibiotic Cost		
sodium cephalothin (Keflin [*])	— 48 hrs (8 doses)	\$48
cephalexin monohydrate (Ancef [*])	— 48 hrs (8 doses)	48
cefazolin sodium (Keflex [*])	— 1 g-day (\$2) x 4 days	8
	x 5 days	10
	x 6 days	12
Approximate Cost Saving		
VH with repair		
AB cost (\$48 + \$8)		\$56
Room saving (\$60 [*] x 1.5)		90
Net saving		\$34
VH without repair		
AB cost (\$48 + \$6)		\$54
Room saving (\$60 x 0.5)		30
Increase		—\$24
Abdominal hysterectomy—no difference		

^{*}semi-private room cost

ence between patients who received antibiotics and those who did not in the vaginal hysterectomy with repair group. The postoperative morbidity was 87 percent in patients receiving no antibiotics; 30 percent in patients who received antibiotics. In addition, the postoperative stay was reduced by 1.5 days in patients receiving antibiotics. In vaginal hysterectomy without repair, there was a considerable difference: 50 percent morbidity in patients receiving no antibiotics and 24 percent in those receiving antibiotics. The difference in postoperative stay was less significant—only 0.5 days. In abdominal hysterectomies, there was little difference in postoperative morbidity (36 percent compared to 40 percent) and a slight (0.1 days) increase in hospital stay in pa-

tients receiving antibiotics.

Figure 2 shows the approximate hospital cost of administering antibiotics compared to cost-saving in patients discharged earlier as a result of antibiotic use. For patients with vaginal hysterectomy with repair, the net saving was \$34; in patients without repair there was an increase in cost of \$24 when antibiotics were used. In abdominal hysterectomy, there was little difference.

COMMENT

This review of 146 patients treated in our own setting and by our own methods has resulted in the following changes in our use of antibiotic prophylaxis:

(1) Patients with abdominal hysterectomies, unless obviously in-

fect, will receive no prophylactic antibiotics;

(2) Vaginal hysterectomies without repair will not receive routine antibiotics unless there seems obvious need based on the clinical condition of the patient before surgery;

(3) In vaginal hysterectomy with repair, and relying on observations of those who have used antibiotics prophylactically, we will use preoperative antibiotics to attempt to establish a satisfactory blood level during surgery. Our method will include preoperative intramuscular administration of ampicillin or a similar drug and parenterally for 24 hours thereafter. If a urethral catheter is required, oral sulfonamide or antibiotic will be given and guided as indicated by urine cultures.

SUMMARY

Review of 146 patients who underwent hysterectomies of various types during 1973 in the joint practice of three gynecologists in Greenville, North Carolina, indicates that the use of antibiotics appeared beneficial in patients with vaginal hysterectomy with repair, of less significance in vaginal hysterectomy with no repair and of little value in patients with abdominal hysterectomy unless infection is present. As a result, the use of prophylactic antibiotics in hysterectomy will be more selective.

References

- 1 Spruill FG, Minette LJ, Sturmer WO. Two surgical deaths associated with cephalothin. JAMA 229: 440, 1974
- 2 Edgerton CD. Personal Communication, 1974

And indeed most parishioners felt deprived of a great pleasure when, after a week of separation from society, of a routine of prosaic farm-work, they were prevented from seeing their friends parade into church, from hearing the psalm-singing and the sermon, and listening to the news afterward. It was like going to mass and going to the theater and the opera, and making a round of short calls, and having an outing on one's own best clothes to see other people's, all rolled into one; beside which, there was (and is) a superstitious expectation of good luck in the coming week if the religious obligations were carefully fulfilled. — *A Country Doctor*, Sarah Orne Jewett, 1884, pp 118-119.

Editorials

THE POWER OF THE PURSE

Revealed religion to its adherents is the road to salvation, virtually all dissent being considered misguided, uninformed or downright perverse. One of the shibboleths of modern political and sociological religion has been that the federal treasury offers solutions to most of our problems, that the dollar possesses a certain self-correcting righteousness which confers grace on its recipients and redeems the shortcomings of environmental obstacles and genetic restrictions. Unfortunately such beneficence often leads to a vacation of judgment and a loyalty to the perceived party line which bodes badly for unbelievers and occasionally for ex-zealots. Federal funds follow fashion and often dictate the direction and sector of booms without anticipating the consequences a decade or so afterwards. In the 1960s colleges embarked on great expansions in the face of decreasing birth rate and in the certainty that a manipulated economy would escape depression and avoid inflation. Now we have empty dormitories, particularly in private colleges, endowments are dwindling and crises abound.

Medicine increasingly feels the force of the federal dollar as an overwhelming number of costly programs are being thrust upon us, whether we be of town or gown. Thus an excerpt of a speech delivered by Kingman Brewster, president of Yale University, to the fellows of the American Bar Association February 22, 1975, is particularly pertinent. It is reprinted here by permission of Mr. Brewster and of *Science* in which it appeared April 11, 1975.

COERCIVE POWER OF THE FEDERAL PURSE

Use of the leverage of the government dollar to accomplish objectives which have nothing to do with the purposes for which the dollar is given has become dangerously fashionable, and there is no obvious constitutional basis on which to resist this encroachment.

The difficulty of obtaining review of a denial of a grant or a contract makes the allocation or withholding of funds easy to manipulate for vindictive or political purposes. This was precisely what was proposed in order to get back at Jerome Wiesner for his opposition to the antiballistic missile program.

There have been other less flagrant, but equally

pernicious, efforts to use the leverage of the spending power to "discipline" educational institutions. The most notorious was Congressman Hubert's persistent effort to deny all Department of Defense grants to any institution which discontinued its Reserve Officers Training program.

Another example of use of the leverage of the government dollar is the proposed health manpower legislation. With laudable motive and seeming plausibility, this legislation seeks to remedy the shortage of primary care physicians and the obvious uneven availability of medical care throughout the country. It does not use the device of special assistance for the training of primary physicians, or special bounties for graduates who commit themselves to practice where they are most needed. It proceeds, rather, by telling the medical schools that all general support for medical education, the so-called capitation grants, will be withdrawn unless a school increases its general practice training and requires some proportion of its graduates to enter practice where there is a shortage of doctors. Were it not for the federal financial support it would be hard to find warrant in the Constitution for federal regulation of medical school curricula or for drafting graduates to serve in places not of their choice.

This same leverage is carried to far greater extremes in other federal legislation already on the books. It might be called the "now that I have bought the button, I have a right to design the coat" approach. Thus if we are to receive support for physics, let's say, we must conform to federal policies in the admission of women to the art school, in the provision of women's athletic facilities, and in the recruitment of women and minorities, not just in the federally supported field, but throughout the university. Even in the name of a good cause such as "affirmative action," this is constitutionally objectionable.

The farthest outreach of federal regulation under the banner of the spending power is the Family Educational Rights and Privacy Act, the so-called Buckley Amendment to the Education Act. Again, the purpose is laudable. Schools should not be able to build up prejudicial files on students against which the student has no redress if he has no way of knowing what is in them. But the end does not justify the means in this case either.

We all remember the warning of former President Eisenhower against the dangers of the military-industrial complex, but hardly anyone remembers that

Excerpted from a speech delivered to the Fellows of the American Bar Association on 22 February 1975.

he went on to say, "The prospect of domination of the nation's scholars by federal government, project allocation, and the power of money, is ever present, and is gravely to be regarded."

High on the agenda of the legal profession, especially its scholarly branch, should be to see to it that, in terms of both limits on authority and redress against

its abuse, the coercive power of the federal purse is made subject to a rule of law.

It is high time that we learn once again to ask not only "Is your objective worthy?" but also "Are the means you would use consistent with the values of the Constitution?"—KINGMAN BREWSTER, *President, Yale University, New Haven, Connecticut 06520*

Emergency Medical Services



EDUCATION IN EMERGENCY ROOMS: SOME CONSIDERATIONS

Michael M. Stewart, M.D., M.P.H.
**Director, Department of Ambulatory
Care and Community Medicine**
City Hospital Center at Elmhurst, N. Y.
79-01 Broadway
Elmhurst, N. Y., 11373

Although those involved in education in emergency medical services have tended to focus on graduate physician training, there is considerable unexploited potential for other forms of education in emergency medicine.

1. *Undergraduate medical students*—As long as educational objectives are clearly defined and supervision is available, and the guidelines for student participation are sufficiently clear, the busy urban hospital emergency room is an exciting and valuable educational experience for the medical student at all levels.

2. *Graduate students in health administration*—Students of health administration and health planning can contribute to the solution of many of the complex inter-reaction of demands, resources, policies, and various administrative and organizational constraints which can be seen in any health care system. They should be given an opportunity to observe this.

3. *Physician's associates, nurse practitioners, and other allied health workers*—Although it is not yet clear to what degree training programs for various health professions should include assignments to emergency departments, it is apparent that with proper supervision, some of these can have valuable learning experiences in well-organized emergency units.

4. *Community health and social work training*—Emergency departments provide a rich opportunity for understanding social and medical needs and to what degree the community expectation is met by existing emergency care and referral systems.

With the growing national recognition of the importance of primary care, those responsible for emergency services should actively explore new educational potentials in their emergency rooms for a wide variety of health professionals.

—Abstracted by GEORGE JOHNSON, JR., M.D.

From "Emergency Medicine Today," Vol. 4, No. 5, May 1975, editor, John M. Howard, M.D. Original article may be obtained from the Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

Brodie, Harlow Keith Hammond, MD (P), Box 3950, Duke Medical Center, Durham 27710
Congdon, Edgar Dana, MD (P), Rt. 7, Box 290, Hendersonville 28739
Cook, Stephen George, MD (OPH), 3535 Randolph Rd., Charlotte 28211
Davis, John D., Jr. (STUDENT MEMBER), 210-D Branson St., Chapel Hill 27514
Dawkins, Howard Garrett, Jr., MD (Intern-Resident), 2467 Foxwood Drive, Chapel Hill 27514
Elks, Martha Louise (STUDENT MEMBER), 204 Cottage Lane, Chapel Hill 27514
Ellis, Randy Sue (STUDENT MEMBER), 132 Hamilton Rd., Chapel Hill 27514
Harris, Samuel Ranchor, MD (OBG), 202 W. Center St., Lexington 27292
Michel, Randall George, MD (Intern-Resident), 5830 Shamrock Rd., Durham 27701
Raju, Vegesena Prudhui, MD (EM), 1207 Decatur Road, Jacksonville 28540
Scarpitti, Edward Henry, MD (U), 625 Decatur Road, Jacksonville 28540
Sias, Charles Robert, MD (EM), 715 Fleming St., Hendersonville 28739
Smith, Stephen Wayne, MD (Intern-Resident), Rt. 3, 50 Red Pine Road, Chapel Hill 27514
Thigpen, Fronis Ray (STUDENT MEMBER), Apt. 6, Kingswood Apts., Chapel Hill 27514
Tucker, Walter Robert, MD (Intern-Resident), 1509 Woodland Drive, Durham 27701
Zelneronok, Nicholai, MD (U), P. O. Box 7204, Jacksonville 28540

WHAT? WHEN? WHERE? In Continuing Education

September 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

September 18-21

Invitational Assembly for Advanced Urology: Pediatric Urologic Problems
Place: Pinehurst Hotel and Country Club, Pinehurst
Fee: \$135
Credit: 18 hours
For Information: James F. Glenn, M.D., Division of Urology, Duke University Medical Center, Durham 27710



Pro-Banthine®

brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE

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Address medical inquiries to: G. D. Searle & Co.
Medical Department, Box 5110, Chicago, Ill. 60680 481

September 19

Child Abuse and Neglect Seminar

Credit: 6 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

September 22-26

Perceptual Motor Workshop

Place: Central Piedmont Community College, Charlotte

Sponsors: The Center for Human Development and the Charlotte Area Health Education Center

Program: The program "will make available the latest information on multi-disciplinary intervention in perceptual motor dysfunction."

Credit: 3.0 for teacher recertification; also approved for nursing CERP and for CEU. Enrollment limited to 225.

For Information: Jeanne A. Palmer, Coordinator for Allied Health Education, Charlotte Area Health Education Center, P. O. Box 2554, Charlotte 28234

September 24-27

North Carolina Medical Society Annual Committee Conclave

Place: Mid-Pines Club, Southern Pines

Regular meetings will be scheduled for the chairman and members of almost all regular committees of the Medical Society. Committee members should plan to be present if at all possible.

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

September 25

"The Skin as a Mirror of Systemic Disease," Moore Memorial Hospital Continuing Education Series

Place: Country Club of Southern Pines (Elks Club)

Sponsor: Moore Memorial Hospital; UNC School of Medicine

Fee: \$11.50

Credit: 2 hours; AMA Category I & AAFP approved

For Information: C. H. Steffee, M.D., P. O. Box 3000, Pinehurst 28374

September 25-27

Fifth Annual Seminar in Medicine

Fee: \$100

Credit: 15 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 1

Fifth District Medical Society Meeting

Place: Country Club of North Carolina, Pinehurst

Speakers and topics will be: Newton C. Brackett, Jr., M.D., Associate Professor of Medicine, Nephrology Division, Medical University of South Carolina — "The Use and Abuse of Diuretics"; Robert Cowan, M.D., Associate Professor of Radiology and Nuclear Medicine, Bowman Gray School of Medicine — "The Role of Nuclear Medicine in Oncology"; Giller R. G. Monif, M.D., Associate Professor, Department of Obstetrics and Gynecology, University of Florida College of Medicine — "Venereal Diseases of the New Morality."

For Information: Eric Larsen, M.D., Secretary-Treasurer, Fifth District Medical Society, Pinehurst Surgical Clinic, P.A., Pinehurst 28374

October 1-2

Fifteenth Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital Auditorium

Sponsor: Mecklenburg County Chapter American Academy Family Physicians

Co-sponsors: North Carolina Academy Family Physicians; Mecklenburg County Medical Society; Charlotte Memorial Hospital
Program: Topics will include diseases of the gastrointestinal tract, hypertensive heart disease, emergency room practice, respiratory diseases, marital and sexual counseling, and arthritis in children

For Information: Mrs. Farrior Harloe, 1336 Brockton Lane, Charlotte 28211

October 4-9

American Institute of Ultrasound in Medicine and the American Society of Ultrasound Technical Specialists Annual Conference
Place: Benton Convention Center, Winston-Salem

Program: The program will include presentation of scientific papers on diagnostic ultrasound and advanced instrumentation, lectures on basic and advanced diagnostic ultrasound education,

scientific exhibits and a display of commercial equipment.

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 9-12

4th Annual Conference on Medicine and Ministry of the Whole Person

Place: Lake Junaluska Assembly

Sponsor: The Conference on Medicine and Ministry of the Whole Person

Fee: \$75; couple \$125

For Information: Norman Boyer, M.D., Box 88, Tryon 28782

October 10

26th Annual Winston-Salem Heart Symposium

Place: Babcock Auditorium, Bowman Gray School of Medicine

Fee: Physicians \$20; nurses \$10

Credit: 6 hours; AAFP approved

For Information: Mrs. Betty Cauthen, Forsyth County Heart Association, 2046 Queen Street, Winston-Salem 27103

October 17-18

Seventh Annual Duke Symposium on Orofacial Anomalies

Credit: 12 hours; AAFP credit applied for

For Information: Raymond Massengill, M.D., Department of Surgery, P. O. Box 3523, Duke University Medical Center, Durham 27710

October 17-18

Office Management of Marital and Sexual Problems

Fee: \$100 (includes spouse)

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 20-24

Endocrinology and Metabolism Symposium

Sponsors: Department of Medicine, Duke University Medical Center, and the American College of Physicians

For Information: Harry McPherson, M.D., Box 3006, Duke University Medical Center, Durham 27710

October 24

"Priorities in the Treatment of Patients with Multiple Injuries,"

Moore Memorial Hospital Continuing Education Series

Place: Country Club of Southern Pines (Elks Club)

Sponsor: Moore Memorial Hospital; UNC School of Medicine

Fee: \$11.50

Credit: 2 hours; AMA Category I & AAFP approved

For Information: C. H. Steffee, M.D., P. O. Box 3000, Pinehurst 28374

October 30

Diagnosis and Treatment of Sleep Disorders

Credit: 2 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 3-7

Current Concepts in Pediatric Radiology

Place: Pinehurst Hotel, Pinehurst

Program: There will be a systems oriented format covering Cardio-pulmonary diseases on Monday, Gastro-intestinal diseases on Tuesday, Genito-urinary diseases on Wednesday and Musculoskeletal diseases on Thursday, "with Friday left for miscellaneous disorders."

Credit: 25 hours

For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham 27710

November 7

Scientific Session. Alumni Association, Bowman Gray School of Medicine

Credit: 5 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 21-22

Second Annual Arthritis Symposium

Fee: \$35

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Con-

tinuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 5-6

Family Practice Workshops

Credit: Credit hours have not yet been determined

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 6-7

Endoscopy Workshop

Place: Berryhill Hall

Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine

Fee: \$75

For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient

Fee: \$100

Credit: 15 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 11

Wingate M. Johnson Memorial Lecture

Place & time: Babcock Auditorium, 11:00 a.m.

Speaker: Dr. Grant Liddle, Professor and Chairman, Department of Medicine, Vanderbilt University School of Medicine

Credit: 2 hours

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 22-26

Radiology of the Urinary Tract—a Tutorial Postgraduate Course
Program: Emphasis on personalized small group tutorial type teaching. Subject matter will cover all facets of urinary tract disease, including comprehensive coverage of diagnostic techniques.

Fee: \$300

Credit: 30 hours

For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham 27710

ITEMS OF SPECIAL INTEREST

October 4-7

Southern Psychiatric Association Annual Meeting

Place: Houston Oaks, Houston, Texas

For Information: Mrs. Annette Boutwell, P. O. Box 10387, Raleigh 27605

November 3-8

Course in Laryngology and Bronchoesophagology

Program: Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

For Information: Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association

Place: Miami Beach, Florida

For Information: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205

Continuing Education for Nurses

For information on the following continuing education opportunities, write to Judith Wray, Admin. Secretary, Continuing Education Program, UNC-CH School of Nursing, Chapel Hill 27514

September 22-26: Practical Approaches to Diabetic Care

Fee: \$125

September 25-26: Human Sexuality Workshop. Fee \$50

October 9-10: New Look at Patient Teaching

Fee \$50. Enrollment limited to 35 participants

September 29-October 3 and November 3-7: The Patient with Acute Respiratory Failure — Nursing Assessment & Intervention

October 2-3: Primary Nursing. Fee \$50

October 21: Practical Approach to Drug Interactions

Fee: \$30. Enrollment limited to 32 participants

October 30-31: Family Centered Maternity Care. Fee \$50 for 2 days; may choose to attend for one day only

November 6-7: Nursing Audit. Fee \$50

November 10-12: The Nurse: Planning Classes for Expectant Parents. Fee \$75

November 17-21: Nursing Process. Fee \$112

James M. Johnson Awards are available to assist in covering the costs of the above workshops.

PROGRAMS IN CONTIGUOUS STATES

September 24-26

The Practical Application of Recent Surgical Advances

Place: Richmond Hyatt House, West Broad Street Road at Interstate 64, Richmond, Virginia

Sponsors: The Department of Surgery, in cooperation with the Department of Continuing Education

Fee: First half day \$60; registration limited to first 60 paid registrants who also will attend the course on Thursday and Friday. Fee for 2nd and 3rd days, \$125; registration limited to 150. Visiting interns and residents \$15; preregistration required.

Credit: 18 hours; AMA Category 1; AAFP approved

For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

September 26-27

The Adolescent in Office Practice — Sixth Annual Symposium

Place: The University Club of Nashville, 2402 Garland Avenue

Sponsors: Department of Pediatrics and Division of Continuing Education, Vanderbilt University School of Medicine; Tennessee Chapter, American Academy of Pediatrics; Tennessee Pediatric Society; Davidson County Pediatric Association; Tennessee Academy of Family Physicians; Children's Hospital of Vanderbilt University

Fee: \$30; no fee for students, house staff, faculty, members of the Tennessee Pediatric Society and the Tennessee Chapter, American Academy of Pediatrics

Credit: 8 hours; AMA Category 1; AAFP approved

For Information: Division of Continuing Education, Vanderbilt University School of Medicine, 305 Medical Arts Building, 1211-21st Avenue South, Nashville, Tennessee 37212

October 16-17

The 47th Annual McGuire Lecture Series — a Postgraduate Course in Common Problems in Dermatology

Sponsors: Department of Continuing Education and Department of Dermatology

Fee: \$95

Credit: 10 3/4 hours; AMA Category 1; AAFP credit applied for

For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, MCV Station, Richmond, Virginia 23298

October 20-21

Tennessee Valley Medical Assembly annual meeting

For Information: Clifton R. Cleaveland, M.D., Tennessee Valley Medical Assembly, Whitehall Medical Center, 960 E. Third Street, Chattanooga, Tennessee 37403

November 13-15

Adolescent Medical and Social Problems

Place: Baruch Auditorium

Sponsors: Department of Continuing Education and the Section of Adolescent Medicine, Medical College of Virginia

Fee: \$80; enrollment limited to 270 participants

Credit: 15 hours; AAFP approved; approved American Academy Pediatrics

For Information: Dr. George M. Bright, Director of Adolescent Medicine, Box 151-Adolescent Clinic, Medical College of Virginia, Richmond, Virginia 23298

December 7-10

Structure-Function Correlations in Cardiovascular Disease

Place: Williamsburg Conference Center, Williamsburg, Virginia

For Information: Miss Mary Anne McInerney, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

In past years, the national headquarters of the Auxiliary to the American Medical Association has given state and county auxiliaries each year a theme for endeavor which has usually been selected by the new national president. This custom continued until state and county auxiliaries began to protest. It wasn't that they objected to worthy projects; they never quite finished what they had started. Sometimes, annual themes had little local appeal or the facilities or the numbers to handle a theme were not available or there was a lack of interest on the part of the membership.

National headquarters listened to the rumblings and this year has presented a new program to the state and county auxiliaries. It amounts to doing your own thing. What is more, the headquarters has a collection of ideas in every area of auxiliary interest which are available for the asking—the Project Bank. There is a

catalogue each auxiliary can use for ready reference to select a project.

The North Carolina Medical Auxiliary has the Project Bank catalogue mimeographed and for \$3, it can be ordered from Mrs. Baxter Troutman, 521 Mountain View Street, SW, Lenoir, North Carolina 28645. The catalogue contains cards with brief descriptions of auxiliary programs which have been used. It tells where they have been used, the purpose, the population of the county that used them and/or the number of members in the auxiliary. In most instances, number of volunteers involved is given. No auxiliary is limited to one project. It is a question of how many can be managed by interested members.

What are some of the projects auxiliaries have tackled? High Point, North Carolina, had a project called "Egammur" — a city-wide rummage sale held at the city armory. There was a two-fold purpose for the project: (1) to raise money to sponsor other projects, and (2) to offer good quality secondhand items for sale. Of 83 members in the High Point Medical Auxiliary, approximately 70 participated in the project.

In Anderson County, South Carolina, the medical



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Medical examination upon admission.



Modern, motel-like accommodations with private bath and individual temperature control.



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- The Alcoholic & Drug Problems Assn. of North America
- American Hospital Association

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JAMIE CARRAWAY
EXECUTIVE DIRECTOR
919-621-3381

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FOR MEDICAL INFORMATION CALL
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MEDICAL DIRECTOR
919-275-6328

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and the Greensboro Regional Airport.

FELLOWSHIP HALL WILL ARRANGE CONNECTION WITH COMMERCIAL TRANSPORTATION.

auxiliary sponsored a Uterine Cancer Task Force and Clinic. The purpose of this was to provide a Pap smear for every woman over age 20 by 1976. The population of the county is 100,000 and there are 60 auxiliary members; 50 auxiliaries, 12 physicians and 125 community volunteers took part.

Eau Claire, Wisconsin, came up with a very unusual but worthwhile project. Ten volunteers from the auxiliary collected wigs (there are a surprising number on closet shelves) which were given to cancer patients suffering from hair loss. The auxiliary states as its purpose in the project: "to cooperate with established organizations in a health program" — an elaborate explanation perhaps for what might have been a great morale booster for patients.

Mrs. Edwin H. Martinat, 120 Sherwood Forest Road, Winston-Salem, North Carolina 27104, is the North Carolina chairman for the Project Bank. Any auxiliary interested in a program should write to Mrs. Martinat who will obtain information from the National Project Bank giving the details of any given effort.

Each auxiliary in the state should first assess its community needs and try to satisfy major unmet needs. Cooperation with other groups, including the medical society, is urged for efficient organization.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Alvin Brodish has been appointed professor of physiology and chairman of Bowman Gray's Department of Physiology and Pharmacology.

He comes to Bowman Gray from the University of Cincinnati where he had been a member of the faculty since 1967. Prior to that, he was on the faculty of Yale University for 10 years.

He received the undergraduate degree from Drake University, the M.S. degree from the University of Iowa and the Ph.D. degree from Yale University.

* * *

Dr. Richard G. Weaver, professor of ophthalmology, has been appointed chief of the Section on Ophthalmology of Bowman Gray's Department of Surgery. Dr. Weaver succeeds Dr. R. Winston Roberts, who headed the section since 1948.

Dr. Roberts is retiring from the Bowman Gray faculty late this fall.

Dr. Weaver joined the Bowman Gray faculty in 1954. He received the M.D. degree from Washington University School of Medicine. He is an associate chief of professional services at North Carolina Baptist Hospital.

* * *

Dr. Clark E. Vincent, professor and chairman of the

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

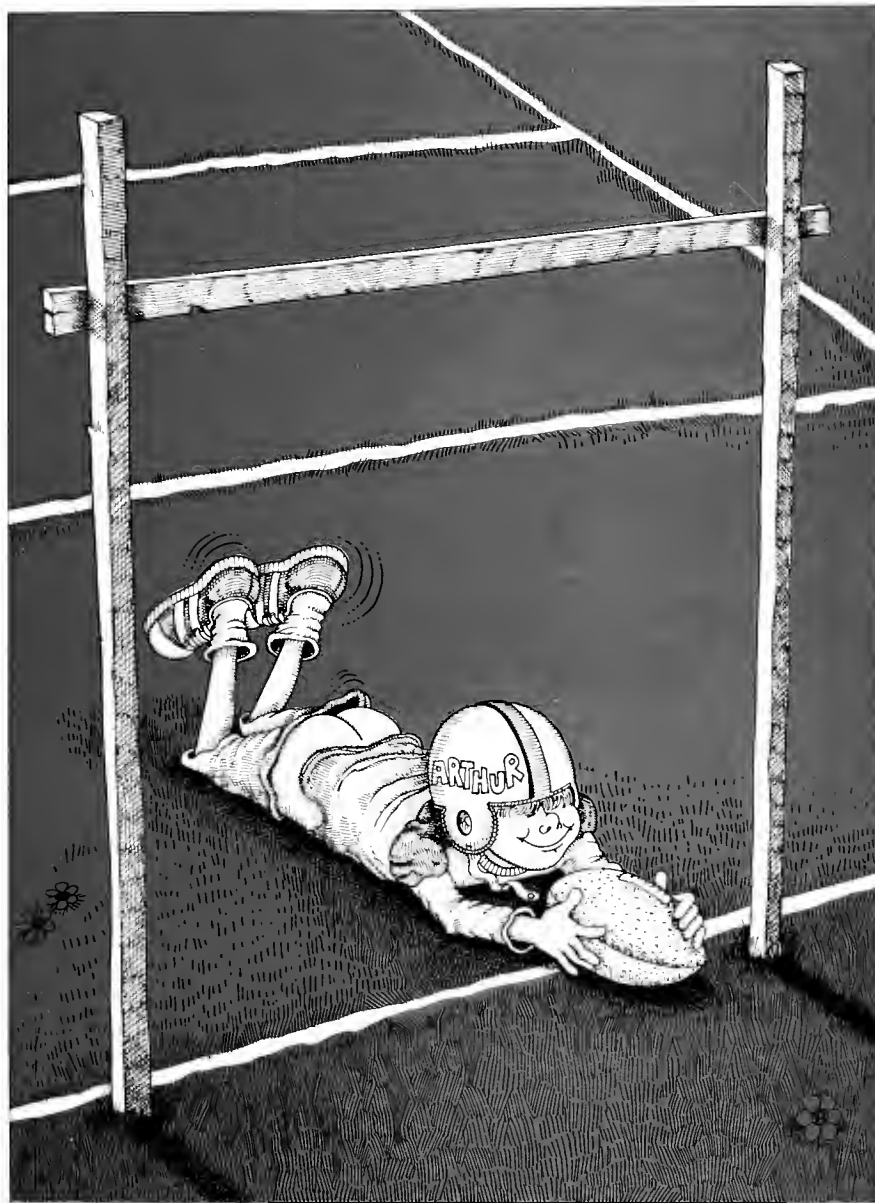
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs. — maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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**Pinworms, roundworms controlled
with a single, non-staining dose of**

ANTIMINTH[®]
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

Department of Medical Social Science and Marital Health, has been named associate editor of the *Journal of Marriage and the Family*, the official publication of the National Council on Family Relations.

He also has been named to a three-year term on the editorial advisory board for the *Journal of Marriage and Family Counseling*, the official publication of the American Association of Marriage and Family Counselors.

* * *

Dr. John D. Tolmie, associate professor of anesthesia, has been named associate dean for student affairs.

He succeeds Dr. C. Douglas Maynard, professor of radiology, who has held the position since 1971. Dr. Maynard has relinquished his work in student affairs to devote his full attention to nuclear medicine. He is chief of the Section on Nuclear Medicine of the Department of Radiology.

Dr. Tolmie joined the Bowman Gray faculty in 1970. He holds the M.D. degree from McGill University School of Medicine.

* * *

A new radiology textbook, written by Dr. Isadore Meschan, professor and chairman of the Department of Radiology, was published this summer.

The book, "Atlas of Anatomy Basic to Radiology," contains 1,131 pages and several thousand illustrations. It is designed primarily for practicing radiologists and advanced students in radiological residency training.

* * *

Dr. James E. Turner, assistant professor of anatomy, has received a \$96,000 grant from the National Institute of Neurological and Communicative Disorders and Stroke to study regeneration of central nervous system tissue in lower vertebrates.

* * *

The Bowman Gray School of Medicine has received a National Research Service Award to support the training of young researchers in heart and vascular disease.

The award, from the National Heart and Lung Institute, will provide more than \$500,000 in training funds over a five-year period.

Dr. Richard W. St. Clair, associate professor of pathology, will direct the program of training for six graduate students and three post-doctoral fellows each year.

Most of the students at Bowman Gray will concentrate on atherosclerosis research. The training will be closely coordinated with the medical school's Specialized Center of Research (SCOR) in arteriosclerosis. Bowman Gray is one of 13 such centers in the nation.

* * *

Dr. Cornelius F. Strittmatter, professor and chairman of the Department of Biochemistry, has been named to a two-year term on the Council of the Association of Medical School Departments of Biochemistry.

Dr. James F. Toole, professor and chairman of the Department of Neurology, has been elected vice president of the North Carolina Heart Association.

* * *

Dr. Richard W. St. Clair, associate professor of pathology, has been elected president of the Forsyth County Heart Association.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Colin G. Thomas, chairman of the department of surgery at the UNC School of Medicine at Chapel Hill, has been awarded a four-year \$103,925 National Cancer Institute grant to study the biologic characteristics of thyroid cancer.

While thyroid nodules affect two to four percent of the population, only a few of these are malignant. The award will fund research for developing improved methods of differentiating thyroid cancer from benign disease.

Research also will be devoted to analyzing factors influencing survival in thyroid cancer and to appraising the role of the hormone thyrotropin in thyroid cancer development. Another portion of the study will focus on evaluating the role of suppressive therapy in the treatment of nodular goiter and thyroid cancer. In suppressive therapy, medication is used to try to control the disease.

* * *

Dr. James J. Gallagher, director of the Frank Porter Graham Child Development Center at the UNC-Chapel Hill, has been elected by the membership of the American Association on Mental Deficiency (AAMD) to head their Education Division.

Gallagher, who is also Kenan Professor of Education, will serve until May, 1977, as AAMD's vice president of the Education Division. The division promotes advancement in the field of special education for the mentally retarded.

* * *

New Faculty, UNC School of Medicine

Claude T. Nuzum, associate professor, Department of Medicine, holds the A.B. and M.D. from Harvard and the B.A. and M.A. from Cambridge University. Since 1970 he has been an assistant professor at the University of Kentucky Medical School.

Robert Sakata, associate professor, medical allied health professions, and director, vocational rehabilitation counseling curriculum, has been associate professor and director, Guidance Bureau, at Kent State University where he earned his Ph.D. He holds the A.B. from the University of California and M.A. from California State University.

John J. Soltys, Jr., associate professor, Department

of Psychiatry, comes to the University from West-Ros-Park Mental Health Center where he was director of services to children and youth. A graduate of the University of Massachusetts, he received his M.D. from Harvard Medical School.

Peter C. Ungaro, associate professor, Department of Medicine, attended Oberlin College and received his M.D. from the University of Miami School of Medicine. Since 1973 he has been assistant professor of medicine at the University of Kentucky Medical Center and, for the past year chief of the hematology section at the VA Hospital in Lexington.

Philip A. Anderson, assistant professor, Department of Family Medicine, and clinical director of family practice residency, has just completed three years postgraduate training at the Family Practice Center, Akron City Hospital. He holds his B.S. and M.D. from the University of Michigan.

James F. Browder, III, assistant professor, Department of Surgery, was chief resident in otolaryngology the past year at North Carolina Memorial Hospital. He earned his A.B. and M.D. from UNC and an M.A. from Fordham University.

David J. Delany, assistant professor, Department of Radiology, has been a visiting assistant professor at the UNC School of Medicine for the past three years. A British citizen, he earned his B.A. and M.A. from

Cambridge University and completed his medical training at St. Bartholomew's Hospital of Cambridge University.

James R. Foster, assistant professor, Department of Medicine, comes to the University from the U. S. Public Health Service Hospital, Staten Island, N. Y., where he was assistant chief of cardiology. A graduate of Amherst College, he holds the M.D. from Cornell University Medical College.

Thomas R. Griggs, assistant professor, Departments of Medicine and Pathology, was born in Lexington, N. C., and received his B.A. and M.D. from UNC at Chapel Hill. For the past two years he has been a medical officer with the U. S. Public Health Service.

J. Stephen Kizer, assistant professor of clinical pharmacology and medicine, Departments of Medicine and Pharmacology, comes to Chapel Hill from the National Institute of Mental Health, Bethesda, Md., where he was a research associate in the Laboratory Clinical Science. A graduate of Princeton University, he earned his M.D. degree from Duke University School of Medicine.

Peter M. Levitin, assistant professor, Department of Medicine, holds the B.A. from Franklin and Marshall College and the M.D. from the University of Pennsylvania School of Medicine. For the past two

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Dorothy R. Mooney, Associate Director

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ACCREDITED BY THE J. C. A. H.

years, he has been a fellow in rheumatology at the University of Virginia Hospital.

Lee M. Marcus, assistant professor, Department of Psychiatry, has been clinical director of the Treatment and Education of Autism and Related Communications-Handicapped Children (TEACCH) Center and clinical assistant professor at the UNC School of Medicine for the past year. A graduate of the University of Pennsylvania, he earned his Ph.D. from the University of Minnesota.

Donald C. Nagel, assistant professor, Department of Family Medicine, is a graduate of the UNC School of Medicine. He holds the B.A. from Northwestern University and the master of divinity from Duke University. For the past three years he has been a resident in family medicine at the Medical College of Virginia. An ordained Methodist minister, he was associate pastor of the Cary First Methodist Church from 1963-65 and pastor of Holland's Methodist Church from 1965-67.

Margaret A. Nelsen, assistant professor, Department of Surgery, has been a surgical resident and clinical cancer trainee at the UNC School of Medicine for the past seven years. Last year she was a research associate in surgery. She holds the A.A., B.A. and M.D. degrees from George Washington University.

Roy C. Orlando, assistant professor, Department of Medicine, served as an internist/gastroenterologist in the U. S. Navy Reserve, Naval Hospital Memphis in Millington, Tenn., for the past two years. A graduate of Queens College, he earned his M.D. from Georgetown University School of Medicine.

Jack B. Peacock, assistant professor, Department of Surgery, was born in Laurinburg and received his B.A. from Duke University and his M.D. at Chapel Hill. Since 1970 he has been director of the Trauma Service, William Beaumont Army Medical Center.

Luis Reuss, assistant professor, Department of Medicine, was the L. G. Welt Fellow at the UNC School of Medicine the past year. A citizen of Chile, he holds both the B.A. and M.D. from the University of Chile.

John F. Rogers, assistant professor, Departments of Medicine and Pharmacology, has been an instructor of medicine and clinical fellow in medicine-clinical pharmacology at Johns Hopkins Hospital for the past two years. A graduate of Johns Hopkins, he received his M.D. from the University of Maryland.

Robert W. Sealock, assistant professor, Department of Physiology, is completing a National Institutes of Health postdoctoral fellowship which he spent at the Ecole Normale Supérieure in Paris and Harvard Medical School. A graduate of Iowa State University, he holds the Ph.D. from Purdue University.

Frank M. Volberg, assistant professor, Department of Radiology, received both his B.A. and M.D. from Duke University. For the past two years he has been an assistant professor at Cornell University Medical College.

Stephen Wagner, assistant professor, Department of Medicine, is completing a fellowship in cardiology

Rondomycin[®]

(methacycline HCl)

CONTRAINDICATIONS:

Hypersensitivity to any of the tetracyclines
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN; apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE. Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, Rondomycin[®] (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of Rondomycin[®] (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin[®] (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE LABORATORIES
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Solar keratosis is not an uncommon medical problem.

Of course, the prevalence of keratotic lesions is greater in locations south of the 38th parallel—the so-called "Solar Keratosis Belt"—receiving the greatest amounts of solar radiation. However, solar keratosis can occur among any light-skinned population, usually in persons over 40, wherever people are subject to extended exposure to the sun.

Solar keratoses are generally not difficult to identify.

These skin lesions are usually multiple, flat or slightly elevated, brownish or red in color, papular, dry, rough, adherent and sharply defined. They are found on areas of the skin having extensive exposure to sunlight. Clinical characteristics of the lesions, their predominant location on exposed surfaces, the age of the patient and his skin type are important considerations in the diagnosis.

Solar keratoses can, and should, be treated because they are potentially premalignant.

Chronic exposure to sunlight frequently leads to degenerative changes in the skin. This can often result in the development of multiple, potentially premalignant keratotic lesions. Therefore, early detection and treatment is advisable.

Treatment with Efudex (fluorouracil) provides a high degree of effectiveness with a low recurrence rate, ease and convenience of therapy, low incidence of scarring, excellent cosmetic results in most cases, and a high level of patient acceptability.

Efudex® 5% Cream fluorouracil/ Roche®

Because there may be more than meets the eye.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to

respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dis-

pensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris (hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

ROCHE

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Division of Hoffmann-La Roche Inc.
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at Presbyterian Hospital, Pacific Medical Center, San Francisco. He earned his B.A. at the University of Pennsylvania and M.D. from the University of Rochester.

Dr. Laurel Archer Copp has been appointed dean of the School of Nursing and professor of nursing at the UNC-Chapel Hill, effective Aug. 18, 1975.

Dr. Copp succeeds Dr. Lucy H. Conant, who has served as dean of the School of Nursing for eight years. Dr. Conant will return to her native Massachusetts, where she will remain in nursing and health care on a part-time basis.

For the past three years Dr. Copp has been chief of the Nursing Research and Development Division, Central Office Nursing Service, Department of Medicine and Surgery of the Veterans Administration in Washington, D. C.

* * *

Plants used in folklore remedies for cancer and other ailments will be studied by the UNC School of Pharmacy at Chapel Hill.

Dr. Kwo-Hsiung Lee and his co-investigator Dr. Iris Hall have been awarded an \$80,492 grant from the American Cancer Society to isolate and determine the structure of the active antitumor principles of selected plant extracts. They also will investigate the relationship between the structures of the active principles and their antitumor activity.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

The U. S. Public Health Service has awarded Duke a \$1.5 million grant to train cancer virus specialists.

Supervising the five-year training program will be Dr. Wolfgang K. Joklik, James B. Duke professor of microbiology and immunology and director of basic research for the Comprehensive Cancer Center.

The professor said most of the grant will be used to pay tuition and living expenses of trainees accepted into the program.

* * *

Dr. Jack W. Bonner III has been appointed medical director of Highland Hospital. He succeeds Dr. Charles Neville who has entered private practice in Birmingham, Ala.

The appointment at the Asheville psychiatric hospital, which is a part of the Duke Medical Center, was announced by Dr. Keith Brodie, chairman of the Department of Psychiatry.

Bonner, who has a faculty appointment as assistant professor of psychiatry here, has been at Highland since September of 1971 as a staff psychiatrist. He took his residency training here.

A native of Corpus Christi, Texas, Bonner is a graduate of Del Mar College there and the University of Texas in Austin. He earned his M.D. degree at the

University of Texas Southwestern Medical School in Dallas.

* * *

Duke has a new associate director of medical and allied health education, Dr. Thomas T. Thompson.

He will be responsible for the approximately 20 allied health programs.

At the same time, the Durham VA Hospital appointed Thompson associate chief of staff for education. He has been chief of the radiology service at the VA since January of 1970.

Along with his appointment to the allied health post here, he was promoted to associate professor of radiology.

Thompson, 42, is a native of West Virginia. He attended the University of Virginia, earned an A.B. degree in mathematics and physics at Lenoir-Rhyne College and received his M.D. degree at the Medical College of Virginia in 1964.

* * *

Dr. Frederick R. Hine, professor of psychiatry, has been elected treasurer of the newly organized Association of Directors of Medical Student Education in Psychiatry. More than 60 departments of psychiatry were represented at the organizational meeting in Chicago in late June.

Hine is among those who will draft by-laws for the new organization. He is director of Medical Student Training in Psychiatry here.

* * *

Dr. Donald Bright, orthopaedic chief resident, has recently completed a month's tour to various orthopaedic training centers as one of five North American Traveling Fellows for 1975. Bright was selected by a committee of the American Orthopaedic Association from among participants in 200 training programs in the U.S. and Canada.

* * *

Dr. David C. Sabiston Jr., chairman of the department of surgery, delivered an address on "The Coronary Circulation" at the Twenty-Eighth Annual Rudolph Matas Lectureship at Tulane University. Earlier, he gave the address for the dedication of the new National Research and Demonstration Center at Baylor College of Medicine in Houston.

While there he also gave the annual Alpha Omega Lecture entitled "Commentaries on Some Major Contributions in Surgery." His topic for the dedication was "The Role of Surgery in the Treatment of Cardiovascular Disease."

* * *

Appointments and promotions:

Dr. Joannes H. Karis, appointed professor of anesthesiology.

Dr. Robert J. Bache, promoted to associate professor of medicine.

Dr. David F. Paulson, promoted to associate professor of surgery.

Dr. David C. Deubner, appointed assistant professor of community health sciences.

Dr. Ronald B. Easley, appointed assistant professor of medicine.

Dr. Markku Linniola, appointed assistant professor of psychiatry.

Dr. Calvin R. Peters, appointed assistant professor of surgery.

NEW CANCER CENTER FOR THE UNIVERSITY OF NORTH CAROLINA

The National Cancer Institute has awarded the University of North Carolina School of Medicine at Chapel Hill \$1,230,018 to establish a specialized cancer research center.

Foundations for a variety of Cancer Center programs will be developed during the next three years under the direction of Dr. Joseph S. Pagano, professor of medicine and bacteriology and immunology.

The primary thrust of the Cancer Center at the outset will be directed toward basic laboratory research. Selected areas will be integrated into an interdisciplinary program aimed at developing new approaches to the detection, control and understanding of cancer.

In announcing the award, Dean Christopher C. Fordham, III, and Dr. Joseph S. Pagano said that much significant cancer-related research and many clinical activities are presently underway on the Chapel Hill campus. The new Cancer Center will help provide an interdisciplinary focus for many of these activities.

The new award represents the culmination of efforts by a number of faculty members in various departments over a period of several years. In the early effort, Dr. James Newsome of the department of surgery and Dr. William Pearlman of the department of pharmacology helped to organize an oncology (cancer) faculty effort. This led to the Cancer Center program organization, the appointment of Dr. Joseph Pagano as the Director, and the successful achievement of the award.

With a small group of core faculty as its nucleus, the Center will involve nearly every department in the medical school, as well as other schools in the Division of Health Sciences. Dr. Pagano sees the Center as a forum for identifying areas where cancer research is needed and for encouraging medical faculty to formulate proposals to improve the understanding and treatment of cancer.

Some of the important areas of investigation at Chapel Hill include the role of the body's immune system in fighting cancer, the hormonal control of tumor function and growth, and human malignancies that might be caused by viruses, especially members of the herpesvirus group.

The Center's development will progress in three stages. The initial grant will enable Dr. Pagano and the Cancer Center staff to establish the cornerstone for the future growth of specific programs, all of which will stem from basic laboratory research activities.

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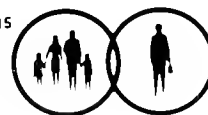
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Center will move into applied research and clinical programs. Dr. Pagano said that the focus again will be interdisciplinary, with the constant goal of upgrading the level of care for cancer patients in North Carolina.

This third developmental phase will be conducted through the Area Health Education Centers in North Carolina so that North Carolinians will have improved access to the latest methods for managing cancer through local hospitals that are linked to the medical school at Chapel Hill.

While concentrating on research, the Center faculty also will work with departments at the School of Medicine to unify the cancer curriculum. They will examine courses currently being taught and will define areas that need improvement.

A member of the UNC-CH faculty since 1965, Dr. Pagano has been director of the division of infectious diseases and the virology laboratory at The North Carolina Memorial Hospital.

As the new director of the Cancer Center Program, he brings to the program a varied research career in cancer virology and medical studies. He has conducted studies at the department of virus research of the Karolinska Institute in Stockholm, the Wistar In-

stitute in Philadelphia and the Swiss Institute for Cancer Research in Lausanne.

He is the chairman of the immunization committee of the Infectious Diseases Society of America, a member of the advisory committee for the Frederick Cancer Research Center of the National Cancer Institute and a consultant to the National Institute of Allergy and Infectious Diseases and the National Institute of Neurological and Communicative Disorders and Stroke, as well as the National Cancer Institute. He also serves on the editorial boards of the *Journal of Virology*, *Cancer Research* and *Intervirology*.

Dr. Fordham and Dr. Pagano indicated that the Cancer Center at the University will ultimately require a Cancer Center Building to accommodate the research and training activities and to enhance the now limited capability of medical scientists to understand, treat and, hopefully in the future, prevent many forms of cancer. A campaign for funds to build the Cancer Center facility (which will cost approximately \$5 million) is to be organized by The Medical Foundation of North Carolina, Inc., a group of distinguished North Carolinians who are supporters of the Medical School's efforts.

Month in Washington

The American Medical Association has filed a lawsuit to block the implementation of new federal drug regulations that would pressure physicians to prescribe low-cost drugs for Medicare and Medicaid patients.

The Maximum Allowable Cost (MAC) regulations were approved in final form by Health, Education and Welfare Secretary Caspar Weinberger a few days before he left office.

Within twenty-four hours AMA filed suit in Northern Illinois District Court contending the program is the epitome in regulatory control—"an impossible labyrinth of drug regulations without assuring a favorable cost-benefit ratio."

The AMA contends the constitutional rights of both patients and physicians would be violated and that the program would produce adversary relationships among patients, physicians and pharmacists.

The disputed regulations would require pharmacists filling prescriptions for Medicare-Medicaid patients, primarily Medicaid, to be reimbursed on the basis of the lowest cost at which the product is generally available to providers. A higher-priced drug reimbursement would be allowed only if the physician signs that

it is "medically necessary." The purpose is to stimulate purchase of generic drugs and discourage purchase of brand names that carry higher costs.

By and large physicians will be affected as they deal with Medicaid patients since there is no substantial outpatient benefit for Medicare. In states with anti-substitution laws, a Medicaid prescription for a brand name more expensive than the MAC would mean the patient would have to make up the difference in price unless the physician would be willing to change the prescription to another brand or generic prescription or sign that it is medically necessary.

At a HEW news conference, officials predicted most physicians would go along with the program, estimating that one-half of one percent would use the "medically necessary" route for brand names that exceed the MAC.

The AMA suit, however, argues that the regulations "violate every one of the drug-reimbursement requirements of the Medicare-Medicaid statutes" and defy the law inasmuch as they represent government interference with medical practice by telling physicians which drugs they should prescribe.

Weinberger estimated the MAC program would

save federal and state governments \$60 million to \$75 million a year when it swings into full operation within three to four years.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them. The aim is to encourage physicians to prescribe cheaper products in their regular, private practice.

No sanctions are provided for physicians who decide to write out the "medically necessary" prescription message, but HEW officials speculated that state health agencies might take a look at physicians who do this consistently for all their Medicaid patients. The possible penalty by the state, if it wishes, would be ouster from Medicaid participation, according to the HEW officials.

Before a Maximum Allowable Cost can be established for drugs, the Food and Drug Administration must first indicate that there are no bioequivalence problems among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers. Before the MAC can officially be established it must be reviewed by a non-governmental advisory committee and published in the Federal Register for comment.

The regulations establish both the Pharmaceutical Reimbursement Board and the 5-member outside advisory group.

HEW said about one quarter of commonly prescribed drugs are available from multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. Program agencies such as a state Medicaid program would make the estimates according to price information supplied on a regular basis by HEW.

The original MAC proposed regulations were amended in some respects. At first, it was recommended that exceptions would be made only if physicians certified the drug was the only one effective or that could be tolerated by the particular patient.

An FDA official said this section was changed in an attempt to meet AMA objections.

The MAC program isn't slated to begin for eight months and will cover at the start some 15 to 20 drug classifications.

Some 2,600 comments were filed with HEW on the MAC proposal with less than 300 favorable.

* * *

A health manpower bill costing \$1.7 billion to aid medical and other health schools has been approved by the House of Representatives.

The measure was stripped on the House floor of a provision that would have regulated residency assignments and ration them by specialty. However,

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a controversial "payback" provision for medical students did survive the floor fight, though it was watered down.

The American Medical Association waged an all-out drive against both the residency control and payback provisions in the first big medical-legislative battle of the Congressional session.

Though the payback plan was retained in the bill, it was changed on the floor to include a "grandfather" clause exempting all current students, and to allow them a total of three years (instead of 11 months) to begin their payback, either in cash or in shortage area services, and allowing forgiveness for military service.

The hotly-disputed payback would amount to some \$2,000 a year, that portion of the individual students' yearly medical education subsidized by the federal government. It marks the first time that general subsidies to schools would be required to be repaid by students at the schools, and is expected to raise legal questions on constitutionality if it becomes law.

As a result of the amendments on the House floor, no one would be faced with the payback requirement until 1985 or 1986 provided the plan is enacted into law and survives possible court challenge.

Some fancy parliamentary maneuvering blunted the anti-payback forces drive. Manager of the bill, House Health Subcommittee Chairman Paul Rogers (D-Fla.) steered through the palliative "payback" amendments before calling for a vote. The vote to support the

provision was 209-153. Under House rules a vote could not then be taken to reject the amended provision.

Leading the battle against the payback plan was Rep. David Satterfield (D-Va.) who charged it "will certainly violate the spirit, if not the letter, of our constitution."

Terming the plan "a finely baited snare," Satterfield said the medical graduate has to make the decision on cash repayment or service "at a time when he is faced with repaying loans made to provide for his education, the cost of setting up an office, paying for malpractice insurance, and perhaps supporting a family."

"The saddest aspect of all is that the ones who will have no choice but to enter into a period of service will be those medical graduates who come from the poorest families or those with moderate incomes, because under the circumstances they will not be able to do otherwise."

The service payback would be on a year-for-year basis, and for those choosing this option, four years of service would be required in most cases. Otherwise, they would have to pay Uncle Sam \$2,000 a year or \$8,000 in a lump sum.

* * *

The House voted to lift the \$36,000 a year salary lid for Veterans Administration physicians and dentists. The measure, approved on a 382-3 vote and sent to

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the Senate, would provide \$5,000 a year in special pay and \$8,500 a year in incentive pay for physicians and dentists working full time for the VA between September 28, 1975 and September 25, 1976. Part-time physicians would be limited to \$41,000 and part-time dentists to \$36,000.

Medical professionals in the armed forces and the Public Health Service previously had been voted bonus pay.

The American Medical Association had urged Congress to approve the higher pay for VA physicians. Still to be resolved is the \$36,000 pay ceiling for other federal physicians under regular civil service.

* * *

The House Ways and Means Subcommittee on Health has opened the first Congressional sessions of the year on National Health Insurance.

Subcommittee Chairman Dan Rostenkowski (D-Ill.) said the purpose was to provide Congress with an overview of the problems involved in NHI and the thinking of experts in the field who are not formally aligned with any outside group seeking passage of specific legislation.

Rostenkowski also announced full-scale formal hearings on NHI will start in early fall at which specific time legislation will be considered.

Four all-day sessions have been conducted to date, with a fifth session scheduled for September.

Here in capsulated form is a sampler of the views

expressed before the subcommittee by some of a host of witnesses:

Dr. E. L. Wynder, President of the American Health Foundation, devoted most of his testimony to urging emphasis in any national program on preventive medicine.

Dr. John Freymann, President of the National Fund for Medical Education, called the present health care system a "monstrosity." At the same time he criticized national health in other countries for stifling innovation. Dr. Freymann urged caution in erecting a national health plan here. "We must build on what we have," he said.

Rashi Fein, Economics Professor at Harvard University, took the approach that NHI is "a hallmark of a civilized" society in which medical care costs are shared so that the poor have equal access. He opposed catastrophic, and without directly saying so appeared to be supporting the labor NHI bill.

Uwe Reinhardt, Economics Professor at Princeton University, noted that West Germany's highly nationalized health care system has a worse infant and maternal mortality rate than the U. S. He said there are many very good points about the American system and warned that there are no legislative panaceas. Not only might legislative proposals not result in improvement of health, "but they may cause developments we do not like."

Herman Somers, Princeton professor, suggested

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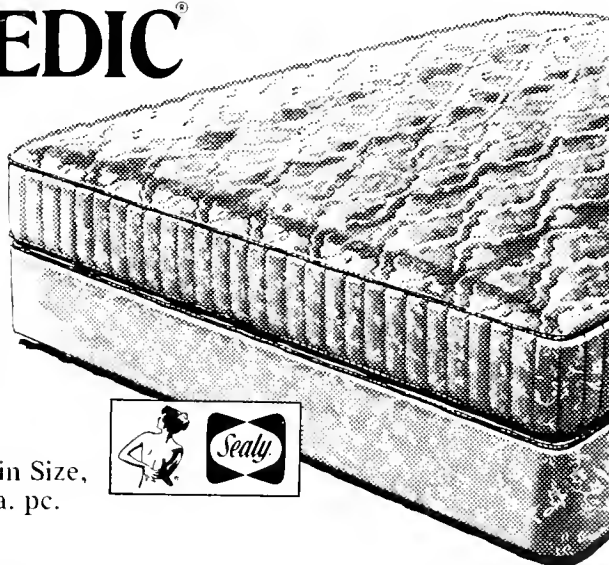
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that the government become more deeply involved in financing of health care costs, not in its administration. Discontent with the U. S. health system is not due to poor conditions but to greater public expectations. Health care is better now than ever. Present problems are due as much to the government as to the private sector's own faults.

Robert England, MD, a private practitioner of Carlinville, Ill., was one of the few non-academic physicians to appear before the subcommittee. He said the Indians of this country are the beneficiaries of complete Federal health care and have the worst health of any group in the nation. Labor's aim, Dr. England said, is to shift health costs to the general public so it can negotiate better wage and other agreements from management. Corporations think the same way, he charged.

John Thompson, President of Blue Shield of Massachusetts, thought Congress should view the NHI debate "not in the perspective of the government's desire to continually expand in numbers and services but rather as to which entity can provide services to the public on the most cost effective basis."

Wilbur Cohen, former HEW Secretary and now the Dean of the University of Michigan School of Education, said he didn't favor enacting any of the NHI bills before the subcommittee. He said developing a NHI bill should be a long and continuing process with time to consult fully providers and consumers. Only the

executive branch can do this, he said, charging the present Administration is "tragically incompetent." This isn't the year for Ways and Means to act on NHI, he said. The public must be fully educated about a NHI. Benefits should be phased in slowly with a definite schedule, and the program should be administered outside of HEW by a board of three to five people. The longer Congress deliberates on NHI, the better. Swift action would be "a tragic mistake" for "so monumental an undertaking."

Martin Feldstein, Economics Professor at Harvard, criticized the incentive health insurance provides for hospitals to produce more and better services yet without providing consumers the protection they need against catastrophic costs.

Herbert Klarman, Economics Professor at New York University, said there's no health care crisis. Some problems today simply reflect past successes. The present system is largely effective. NHI should be a financing instrument only.

Avedis Donabedian, MD, Professor of Medical Care Organization at the University of Michigan, discussed the problems of defining quality care. Too much emphasis should not be given to statistics or to technological procedures at the expense of personal relationships involving physicians and patients. The PSRO program faces two dangers—it might be implemented half-heartedly and it might use the wrong standards. If both results occur, as he predicted they

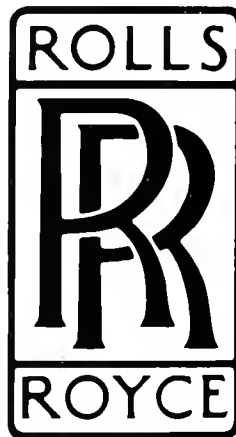
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would, neither much harm nor much good would result, but a large bureaucracy would be created.

Rep. Charles Vanik (D-Ohio), apparently irritated at the defense of the private sector, said most of the doctors he knows think Attila the Hun is a terrible liberal. There are severe problems in health care in

this country, Vanik said, such as finding physicians, waiting in hospitals. Congress doesn't "sit here and dream up plans in the night to extend the gargantuan of the federal government. We are pushed and shoved into this by angry constituents."

Book Reviews

Current Surgical Diagnosis and Treatment, 2nd Edition, by J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1123 pages. Price, \$15.00. Los Altos, Calif.: Lange Medical Publications, 1975.

The esteem of the editors of this surgical text is unexcelled, and their concern for the patient as a person, not just as the bearer of a surgical problem, is stated clearly in the first chapter. While these features alone ensure its value, this text has another excellent feature: the inclusion of chapters not usually seen in the standard surgical text: on the acute abdomen, legal medicine, radiation therapy, and nuclear medicine.

There is an excellent chapter entitled "Special Medical Problems in Surgical Patients" which emphasizes the importance of total care. The chapters on fluid and electrolyte therapy, metabolic and nutritional considerations, organ transplantation and oncology include some of the more recently acquired data and provide an excellent insight into these fields. For example, the chapter on oncology introduces the developing concepts of viral oncogenesis and surgical adjuvant chemotherapy.

For the nonsurgeon or student who wishes an overview of the field of surgery without a great deal of detail, the high degree of organization should make this text appealing. For those interested in pursuing a topic in detail, the references provided at the end of each chapter subtopic and the general references provided at the end of the chapter will allow them to do so.

As with all Lange Publications, the hallmarks of this text are proper and well-done editing, a soft cover, and a manageable size. These features will increase its popularity with those who use it.

JOHN MICHAEL STERCHI, M.D.

Is It Well With The Child? A Parent's Guide to Raising a Mentally Handicapped Child—Strauss, Susan. Doubleday and Co., Inc., New York, 1975. Price, \$7.95.

This is another in a fairly extensive series of books written by a parent with the sincere hope that personal experiences with a handicapped child will be helpful to other parents. The concept is sound and the authors are sincere, but the books are, in general, too narrow in scope to be of real value to parents who must deal with other types or degrees of handicaps in other places and with differing social or economic resources.

Is It Well With The Child? is a mother's very subjective recapitulation of her approach to an adjustment to the reality of her son's handicap. In spite of the publisher's claim that Mrs. Strauss did "extensive research" into facilities for the retarded, there is very little discussion of facilities other than ones in New York, Great Britain and Denmark.

The Strausses are among the fortunate very small minority of parents of handicapped children who can afford private care and training for their children. The entire chapter on choosing a school can only speak to those parents who can afford \$7,500.00 or more per year for the care and training of one child.

I feel that the book adds no new insights and it is certainly not as well written as Pearl Buck's "classic," *The Child Who Never Grew*, which I would prefer to recommend to parents.

ALANSON HINMAN, M.D.

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NORTH CAROLINA

Medical Journal

IN THIS ISSUE: ^{99m}Tc -Pyrophosphate Bone Scans and Endocrinologic Evaluation in a Patient with Eosinophilic Granuloma, James W. Plonk, M.D., and Jerome M. Feldman, M.D.; Amebic Liver Abscess in Vietnam Returnees: Report of Four Cases, Victor L. Stotka, Captain, Medical Corps, U. S. Navy; Anton Chekhov: A Physician-Genius in Spite of Himself, Richard E. Cytowic.

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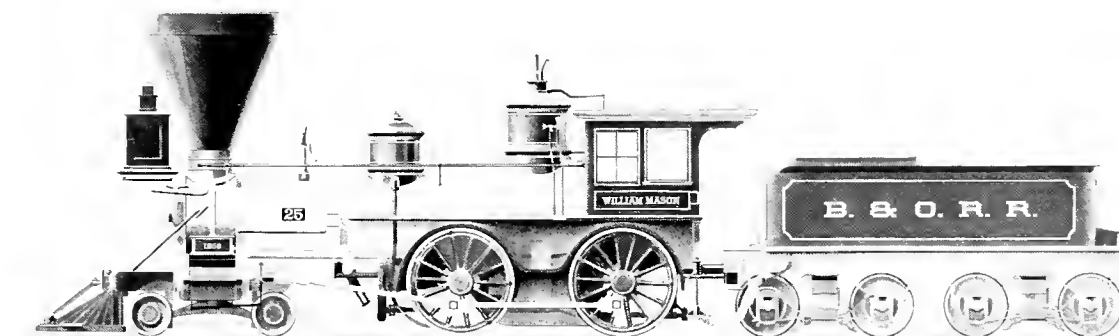
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^{99m}Tc -Pyrophosphate Bone Scans and Endocrinologic Evaluation in a Patient with Eosinophilic Granuloma

James W. Plonk, M.D. and Jerome M. Feldman, M.D.

INTRODUCTION

SINCE its introduction in 1971,¹ ^{99m}Tc -pyrophosphate has become the radionuclide of choice in bone scanning. Its sensitivity in demonstrating bony metastases of malignant neoplasms is superior to other radionuclides such as ^{87m}Sr and ^{18}F . ^{99m}Tc -pyrophosphate, however, is also concentrated in more benign lesions, such as fractures and secondary hypertrophic osteoarthropathy.¹⁻³ Recently we evaluated a patient with eosinophilic granuloma, a disease not readily classified as either benign or malignant. The clinical data presented here emphasize the ^{99m}Tc -pyrophosphate bone scan findings.

CASE REPORT

The patient, a Caucasian man born April 7, 1938, was first evaluated at the Durham Veterans Administration Hospital in September, 1971, for polyuria and polydipsia which began abruptly about one month before admission. He had also noted decreased sexual desire during the month before admission but he retained the ability to

have periodic normal erections and ejaculations. Initial evaluation including complete blood count, serum glucose, BUN, creatinine and liver functions was normal. During water deprivation, the maximum urine osmolality obtained was 123 mosm/kg and the maximum serum osmolality was 313 mosm/kg; the test was discontinued after 12 hours when the patient had lost 5 percent of his body weight. After 5 units of pitressin tannate in oil were given intramuscularly, the maximum urine osmolality was 670 mosm/kg, the polyuria decreased and the serum osmolality remained at 296 mosm/kg. Oral glucose tolerance, serum thyroid hormone concentration and serum growth hormone response to insulin hypoglycemia were normal. Twenty-four hour uptake of ^{131}I was 12 percent. Gonadal function was not tested.

A chest X-ray revealed fibrotic-appearing lesions, resembling old tuberculous lesions in both apical areas. Cultures of sputum and gastric washings for mycobacteria, intermediate strength P.P.D. and fungal skin tests and sputum cytologies were all negative. The patient was discharged taking 5 units of pitressin tannate in oil every other day.

In April, 1972, the patient was readmitted to the hospital for excision of a small cystic lesion on the

left side of his nose. At operation, it was found that the cyst represented the tip of a large cyst protruding from the nasal cavity through the nasal bone to the outside. The cyst, containing yellowish fluid, did not communicate with the sinus cavities or the intracranial cavity. The cyst was drained but could not be entirely removed. Pathological examination revealed the presence of one acid-fast bacterium. Although the histological picture of many large lipid-laden histocystic and chronic inflammatory cells was not typical, the lesion was thought to be tuberculous in origin. The chest X-ray picture had not changed from the previous admission. The patient was begun on a two-year course of isoniazid and ethambutal therapy. During those two years, while he was followed as an outpatient, his endocrinological status remained stable and his chest X-ray showed a questionable enlargement in the apical infiltrates. Multiple sputum and gastric aspirate cultures were negative for mycobacteria.

In March, 1974, due to continued complaints of impotence, gonadal function was evaluated with the following results: serum testosterone 31 ng/dl (normal = 300-1200 ng/dl), serum LH 10 mIU/ml (normal = below 11 mIU/ml), and serum FSH 9 mIU/ml (normal = 4-25 mIU/ml).

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Chest X-ray at that time showed new infiltrates in the left mid lung field and definite enlargement of the apical infiltrates. He was again admitted to the hospital where endocrinological evaluation revealed that the growth hormone response to insulin hypoglycemia was absent. During the same insulin tolerance test, serum cortisol increased by 10 ug/dl, a normal response. Serum FSH concentration was 6 mIU/ml and serum LH concentration was 9 mIU/ml while serum testosterone was 42 ng/dl. A standard metyrapone test was done by administering 750 mg metyrapone orally every four hours for six doses. Serum 11-deoxycortisol rose from a baseline concentration of 1 ug/dl to 7.0 ug/dl at 8 a.m. on the day after metyrapone administration while serum cortisol fell to undetectable levels. Serum thyroid hormone concentration was 5.6 ug/dl, a normal value. A roentgenographic bone survey showed no evidence of bony metastases. A ^{99m}Tc -pyrophosphate bone scan obtained using a Dual 84 rectilinear scanner from Ohio Nuclear is shown in Figure 1. Focal increased uptake was found in the posterior projection at the level of the fourth and ninth ribs. A biopsy of an involved area of the left lung was taken at thoracotomy, and a diagnosis of eosinophilic granuloma was made on the basis of the microscopic appearance of the lesions. Reexamination of the pathological specimen taken from the nasal cyst in 1972 revealed that it was also compatible with the diagnosis of eosinophilic granuloma.

DISCUSSION

The findings of ^{99m}Tc -pyrophosphate bone scans in cases of eosinophilic granuloma have not previously been described, although it is well-known that patients

with this disease may have positive ^{18}F bone scans.⁴ We present here a patient with eosinophilic granuloma involving the nasal cavity and the lung in whom the correct diagnosis was obscured by the incidental finding of an acid-fast organism, perhaps a saprophyte, on microscopic examination of the nasal cavity lesion. In addition, he has diabetes insipidus, hypogonadotropic hypogonadism, and lack of growth hormone response to hypoglycemia, very likely on the basis of the well-known predilection of this disease process to involve the hypothalamus and to cause hypopituitarism. Nuclei in the anterior hypothalamic area have been shown to be important in the regulation of growth hormone and also gonadotrophins in rats,^{5,6} whereas adrenocorticotrophic hormone and thyroid stimulating hormone are influenced by more diffuse neuronal networks. Thus, this patient's loss

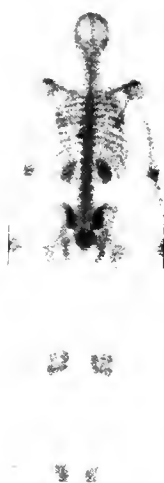


Fig. 1. Posterior ^{99m}Tc -pyrophosphate bone scan. Focal increased uptake is seen in the lateral portions of the left fourth rib and the right fifth rib and in the medial portion of the right ninth rib.

of only gonadotrophins and growth hormone may indicate involvement of only the anterior portions of the hypothalamus. Although there were no lytic lesions in his bones, he exhibited definite increased tracer uptake in his ribs on ^{99m}Tc -pyrophosphate bone scan. It is reasonable to state that these areas of increased uptake are sites of eosinophilic granuloma implants although we do not have direct microscopic evidence. It is also of interest that the pulmonary lesions did not exhibit pyrophosphate uptake as has been demonstrated in soft tissue implants from other cancers.⁷ Unfortunately, a lateral scan of the head was not obtained for evaluation of the uptake of ^{99m}Tc pyrophosphate by the hypothalamic lesion. Eosinophilic granuloma bone lesions are characteristically osteolytic, but it is conceivable that in earlier stages they may not be visible on regular roentgenograms. Positive polyphosphate scans in the presence of normal roentgenogram are a common occurrence when evaluating patients who have widely metastatic cancer. The present report suggests that ^{99m}Tc -pyrophosphate bone scans are useful in evaluating the extent of disease in patients who have eosinophilic granuloma and that ^{99m}Tc -pyrophosphate scans may be of use in following the course of this disease under various modalities of therapy.

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"Land, if you cured her up 't would be like stopping the leaks in a basket," announced Mrs. Martin with a beaming smile, and clicking her knitting-needles excitedly. "She can't hear of a complaint anywheres about but she thinks she's got the mate to it."—*A Country Doctor*, Sarah Orne Jewett, 1884, p 345.

Amebic Liver Abscess in Vietnam Returnees: Report of Four Cases

Captain Victor L. Stotka, Medical Corps, U. S. Navy

INTRODUCTION

THE protozoan *Entamoeba histolytica* was discovered in 1865 and has been recognized as a pathogen for 90 years.¹ In the United States approximately five percent of the population harbors this parasite, yet 90 percent of carriers are asymptomatic.² Clinically ill patients uncommonly develop a secondary liver abscess, and (perhaps for this reason and the varied clinical presentations) the latter diagnosis is not often entertained. Of the few fatal cases of amebiasis reported, however, liver abscess is found in 60 percent.³ Unfortunately, the latent period between exposure and clinical illness can last 15 years, and important historical clues can be forgotten or overlooked.

With the return of large numbers of military personnel from Vietnam, an increased incidence of amebic abscess of the liver was anticipated.⁴ Four Marines were hospitalized at the Naval Regional Medical Center, Camp Lejeune, North Carolina, with this problem in the past four years. All had left Vietnam twelve months or more before hospitalization. The diagnosis

in one man was missed at emergency surgery; another was considered to have a psychoneurosis; the third presented with a relapse of a previously diagnosed liver abscess; and the fourth presented with fever, abdominal pain and leukocytosis. These cases are reported to re-emphasize the difficulty of diagnosing a potentially fatal illness which cannot be considered an exotic rarity in our country.

CASE REPORTS

All patients presented with pain in the right upper quadrant and tenderness to fist percussion of the liver. One patient was mildly anemic and all responded dramatically to antiamebic therapy within several days. Usual treatment consisted of chloroquine hydrochloride (Aralen) 0.5 grams daily for 10 weeks, emetine 65 mg daily for five to 10 days and metronidazole (Flagyl) 0.75 grams three times daily for 10 to 14 days.

Case 1: A 22-year-old Marine admitted October 6, 1970, complained of pain in the right upper quadrant of the abdomen and right shoulder. In June, 1969, he had been hospitalized in the Republic of Vietnam for treatment of acute amebic dysentery. He was medically evacuated to the Naval Hospital at

Yokosuka, Japan, where a diagnosis of amebic abscess of the liver was established. Treatment with chloroquine and a course of emetine resulted in dramatic improvement in the patient's symptoms, but in the months that followed he continued to experience episodes of right upper quadrant abdominal discomfort without associated fever, chills, nausea, vomiting or abdominal cramps. He was treated at various times with emetine, chloroquine, paromomycin, diiodohydroxyquin, tetracycline and metronidazole. When his discomfort persisted and he failed to regain lost weight, he was referred to this hospital for further evaluation.

On physical examination, he was a cachetic man with normal vital signs and in no apparent distress. Significant physical findings included moderate right upper quadrant abdominal tenderness to palpation and a tender, sharp, smooth liver edge palpable two centimeters below the right costal margin.

Laboratory studies revealed a white blood cell count of 6,200/mm³ with a normal differential except for 3% eosinophils, hematocrit 48% and hemoglobin 16.0 grams percent. Liver function studies were normal. The serum hemagglutination test for *E. histolytica* was negative. Stool examinations for ova and parasites

From the Department of Medicine, Naval Regional Medical Center, Camp Lejeune, North Carolina. The opinions or assertions contained herein are those of the author and are not to be construed as official or reflecting the views of the Navy Department or of the Naval Service at large.

were negative. Serial liver scans revealed a "cold" defect in the posterior aspect of the right lobe of the liver which gradually increased in size. Roentgenograms of the chest revealed slight blunting of the right costophrenic angle, with no elevation of the diaphragm to suggest a subdiaphragmatic process. The barium enema, upper gastrointestinal and small bowel roentgenograms were normal.

After a course of treatment with erythromycin, chloroquine and paromomycin, closed needle aspiration of the liver abscess was unsuccessful and the patient was transferred to the surgical service. At operation, a 15 x 20 cm thick-walled abscess of the right posterior lobe of the liver was drained extraperitoneally and extrapleurally of approximately 200 milliliters of thick gelatinous material. Aerobic culture of this material revealed no growth of organisms. No attempt was made to identify cyst or trophozoites of amebiasis. The patient's postoperative course was uneventful, and chloroquine and paromomycin were continued for two weeks after surgery. The patient's appetite improved and he began to gain weight. He resumed full activities after his discharge from the hospital, but then was released from active duty and lost to follow-up.

Case II: A 36-year-old Marine was admitted on August 30, 1971, complaining of progressively increasing burning pain in the right lower chest and in the right upper quadrant of the abdomen for two and a half weeks before admission. Intermittent nausea and vomiting occurred during the week before admission. He denied fever, chills, cough, sputum production, pleuritic chest pain, jaundice or change in bowel habits.

The patient had had transient bouts of bloody diarrhea in 1966 and in 1969 in Vietnam. Both episodes subsided spontaneously without treatment. In 1965 and 1969, he was treated for malarial infections.

On physical examination, the patient was a well-developed and well-nourished man in obvious pain. Vital signs were normal. The

chest was symmetrical, with voluntary splinting on the right. Marked hyperesthesia to light touch was noted over the lower right anterolateral chest wall. The lung fields were clear to percussion and auscultation, and the heart sounds were normal. There was tenderness to percussion and deep palpation of the right upper quadrant of the abdomen. Voluntary guarding prevented adequate evaluation of liver size.

Diagnostic studies revealed a white blood cell count of 7,500/mm³ with a relative lymphocytosis (54%) and 4% eosinophils on differential count, hematocrit 48% and hemoglobin 15.2 grams percent. Liver function studies were normal, as were the serum calcium, phosphorus and amylase levels. Roentgenograms of the chest, upper and lower gastrointestinal tract and gallbladder were normal.

While diagnostic evaluation was being performed, the patient obtained incomplete relief of his pain when treated with thioridazine (Mellaril), diazepam (Valium) and meperidine hydrochloride (Demerol). A psychiatric consultant could find no underlying neuropsychiatric disease. On the ninth hospital day a liver scan revealed a "cold" defect superiorly in the right lobe of the liver consistent with liver abscess. A serum hemagglutination test for *E. histolytica* was reported as "markedly positive" but a titer was not performed.

The patient was treated with chloroquine and metronidazole, and within three days he was free of pain. By the end of the second week he was asymptomatic. A follow-up liver scan in late November, 1971, revealed a slight defect, but a liver scan on June 6, 1972, was normal.

Case III: A 22-year-old Marine was admitted on August 11, 1971, with nausea, vomiting and pain in the right upper quadrant of the abdomen and right lower pleuritic chest pain.

He reported repeated episodes of generalized malaise, nausea, vomiting and diarrhea, along with weight loss while in Vietnam February through April, 1971.

The patient was an ill-appearing

man in moderate distress. His blood pressure was 114/58 mmHg, pulse 100 per minute and temperature 101.2°F orally. Decreased breath sounds were noted over the right lung base. There was tenderness and rigidity over the subcostal and right upper quadrant abdominal areas.

Laboratory studies revealed a white blood cell count of 25,000/mm³ with the differential cell count showing 81% neutrophils, 16% lymphocytes and 3% eosinophils. The hemoglobin was 14.3 grams percent. The following studies were negative or within normal limits: serum amylase; stool, throat and blood cultures; urinalysis; febrile agglutinins and intermediate P.P.D. skin test. Liver function studies obtained seven days after admission revealed an SGOT of 40 mU/ml (normal 0-12 mU/ml), bilirubin of 2.9 mg% total with a direct fraction of 1.9 mg% and a normal alkaline phosphatase. Total protein was 6.7 grams percent with an albumin fraction of 2.4 grams percent. Serum hemagglutination titer for *E. histolytica* was 1:32,000. White blood cell count and liver function tests gradually returned to normal. Chest roentgenograms and flat films of the abdomen on admission were normal. Subsequent chest roentgenograms revealed the development of pleural fluid on the right side which disappeared over the ensuing several days. A liver scan revealed a large defect in the right superior and inferior positions of the right lobe.

The patient appeared acutely ill on admission and was placed on nasogastric suction and intravenous fluids for 24 hours. On the second day, when his condition had not improved, he underwent an abdominal exploration. No pathology was found. An elective appendectomy was performed. Because of an increasing white blood cell count and postoperative fever, the patient was seen by the internal medicine service and found to have abnormal liver function tests, as well as right pleural effusion. When right thoracentesis was performed, a large liver abscess was inadvertently entered and approximately 300 milliliters of anchovy colored

non-foul smelling material were obtained. Microscopic examination of the aspirated material revealed amebic forms. The patient was treated with emetine, chloroquine and metronidazole therapy with marked clinical and laboratory improvement within five days. During the sixth week of his therapy, because of residual discomfort in his right upper quadrant and persistent hepatomegaly, a percutaneous needle aspiration of the liver abscess was performed. Six hundred and fifty milliliters of purulent, non-foul smelling material, brownish-yellow in color were obtained. Thereafter, the patient improved subjectively and clinically, with weight gain and return of well-being. On November 9, 1971, a scan revealed the liver to be moderately enlarged with a minimal residual defect. After discharge from the hospital, the patient resumed full activities. Subsequently, he was released from active duty and lost to follow-up.

Case IV: A 28-year-old Marine was admitted on December 4, 1973, with fever, shaking chills and severe right upper quadrant abdominal pain of two days duration. Transient pain was also experienced in the right shoulder area. He denied cough, nausea, vomiting, jaundice or recent change in bowel habits.

The patient reported having severe, non-bloody diarrhea three weeks after his arrival in Vietnam in May, 1968. The diarrhea subsided with symptomatic treatment. Four months later he developed a transient bout of bloody diarrhea which subsided while shrapnel wounds were treated with antibiotics. After his return to the United States in September, 1968, he continued to have three to five non-bloody bowel movements per day.

Because of increasingly severe abdominal pain with fever and leukocytosis, the patient underwent an exploratory laparotomy on October 23, 1973, at another military hospital. At the time of surgery, the mesenteric lymph nodes were enlarged and the liver was slightly prominent. An elective appendectomy was performed. Postoperatively, the abdominal pain subsided at fever and easy fatigability per-



VSL POSTERO-ANTERIOR VIEW IN INSPIRATION

Fig. 1. Case IV—A markedly elevated right diaphragm noted on chest X-ray in the postero-anterior view, consistent with the clinical picture of subphrenic abscess.

sisted. During that hospitalization, the following studies were negative or within normal limits: stool and urine cultures; roentgenograms of the chest and upper gastrointestinal tract; sigmoidoscopy with multiple mucosal biopsies; liver function studies. The total white blood cell counts ranged from 14,800 to 18,800/mm³, with a slight shift to the left of the differential count. Treatment with ampicillin resulted in the abatement of his fever, and he was discharged to duty.

The recurrence of fever, abdominal pain and marked fatigue precipitated his admission to this hospital. Pertinent findings on physical examination were: oral temperature 101.4°F; pulse rate 112 per minute; dullness and decreased breath sounds over the right lower lung fields with no apparent movement

of the diaphragm on percussion; non-tender liver edge palpable two centimeters below the right costal margin; and non-tender freely movable lymph nodes palpable in the posterior cervical, epitrochlear and axillary areas.

Diagnostic studies revealed a white blood cell count of 16,000/mm³ with a normal differential count. The hemoglobin was 11.8 grams percent and hematocrit 35%. The serum hemagglutination test for *E. histolytica* was positive. Liver function studies revealed a slightly abnormal alkaline phosphatase and SGOT. Stools were positive for ova of hookworm but negative for amebic trophozoites or cyst. Multiple blood cultures and an intermediate tuberculin skin test were negative, as were viral (cytomegalic inclusion), fungal (histoplasmosis,



VSL RIGHT LATERAL VIEW

Fig. 2. Case IV—A "cold" area measuring 15 centimeters in diameter on liver scan, taken in the lateral view.

Blastomyces dermatitidis, coccidioidin) and toxoplasma serological studies. Initial chest roentgenograms revealed elevation of the right hemidiaphragm. Chest fluoroscopy demonstrated paradoxical motion of the elevated right hemidiaphragm with areas of plate-like atelectasis and blunting of the right costophrenic angle, consistent with a subphrenic abscess. Repeat chest roentgenograms on December 6, revealed elevation of the right hemidiaphragm and blunting of the right costophrenic angle (figure 1). The liver scan revealed a "cold" area in the posterior and superior aspect of the right lobe of the liver, which measured 15 centimeters in diameter (figure 2).

Three days after the initiation of treatment with chloroquine and

emetine, the patient became afebrile. His abdominal pains subsided within one week. Diiodohydroxyquin (Diodoquin) was given for 20 days. Thiabendazole (Mintezol) was prescribed for two days for the asymptomatic hookworm infestation. The white blood cell count and mildly abnormal liver function studies returned to normal.

On February 7, 1974, a percutaneous needle aspiration of the liver abscess yielded 600 milliliters of light brown material. Microscopic examination of the aspirated material revealed motile amebic trophozoites. No growth was noted on aerobic and anaerobic cultures of the material. Treatment with metronidazole was prescribed for 14 days after the needle aspiration.

Liver scans on March 13 and

September 16, 1974, revealed a progressive decrease in the small residual filling defect in the liver. The patient has since been performing all his assigned duties without difficulty.

COMMENT

Patients with amebic abscess of the liver frequently have normal liver chemistries,² and use of the serum indirect hemagglutination (HA) test and liver scan offer the best diagnostic aids.^{5,6} Healy and others state that the HA test is positive in over 96 percent of cases of amebic liver abscess.⁵ Of interest is the fact that one of the patients reported herein had a negative HA test despite the presence of an abscess for at least 16 months. Use of the liver scan is important both in diagnosis and in the follow-up treatment of liver abscess.^{6,8} All four of the patients had positive liver scans. All patients with this diagnosis should have repeat liver scans at intervals of six months for two years. Additional follow-up information was not made available after the discharge of Case I. Case I was followed at periodic intervals with a negative liver scan reported in June, 1972. Case III was released from active duty in February, 1972 and lost to follow-up. Case IV remains asymptomatic with a small regressing residual defect in the liver.

Two of the patients had abnormal chest films on admission. One had blunting of the right costophrenic angle, and although not diagnostic this is an important clue that a liver abscess may be present. Ramchandran and others have reported that in patients with amebic liver abscess, certain individuals with elevation of the right dome of the diaphragm in the lateral view showed no significant elevation in the postero-anterior view radiologically.⁷ Another patient had blunting of the right costophrenic angle and diaphragmatic elevation with paradoxical motion consistent with subphrenic abscess.

An inquiry about a history of bloody diarrhea which occurred in Southeast Asia should be a routine part of history taking. A history suggestive of a previous amebic

colitis may be elicited less often as years go by, however, because the frequent nonspecific use of antibiotics may mask the colonic manifestations of amebiasis,¹ delaying the emergence of clinical symptoms. An increased incidence of amebic abscess of the liver was noted after World War II.³ In the

years ahead, clinicians should consider this illness in any Vietnam veteran with obscure abdominal symptoms.

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The preservation of the race is no longer the only important question; the welfare of the individual will be considered more and more. The simple fact that there is a majority of women in any centre of civilization means that some are set apart by nature for other uses and conditions than marriage. In ancient times men depended entirely upon the women of their households to prepare their food and clothing, — and almost every man in ordinary circumstances of life was forced to marry for this reason; but already there is a great change. The greater proportion of men and women everywhere will still instinctively and gladly accept the high duties and helps of married life; but as society becomes more intelligent it will recognize the fitness of some persons, and the unfitness of others, making it impossible for these to accept such responsibilities and obligations, and so dignify and elevate home life instead of degrading it.—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 336-337.

ANTON CHEKHOV: A Physician-Genius In Spite of Himself

Richard E. Cytowic

With this issue, the JOURNAL offers the first of four installments of a study of the great physician, short story writer and dramatist, Anton Chekhov, by a young medical student whose background has given him a particular appreciation of this giant of Russian literature.* The list of doctors whose impulses and compulsions demanded literary expression is endless—Rabelais, Goldsmith, Keats, Oliver Wendell Holmes, Maugham, William Carlos Williams, Weir Mitchell—and Chekhov's name comes close to leading all the rest. The peculiar genius of Russian literature has had its most recent flowering in the person and works of Alexander Solzhenitsyn whose *CANCER WARD* is one of the best novels about medicine ever written. As Mr. Cytowic's essay may suggest, Chekhov and Solzhenitsyn have much in common—compassion, zeal and, in face of extreme adversity, an overwhelming concern for their fellow man. Their writings and their personalities speak particularly to all physicians.

*The bibliography will appear at the end of the fourth installment.

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CHRONOLOGY

Russia did not adopt the new style calendar until 1918. To make dates conform to our calendar, add twelve days for the 19th Century and thirteen for the 20th.

- 1860 January 17: Anton is born in Taganrog.
- 1876 Family flees to Moscow to escape debts, leaving Anton and Ivan behind.
- 1879 Summer: Graduates from the gymnazia. Joins family in Moscow and enrolls in the medical department of the university.
- 1880 First work in print, a comic sketch in the magazine *Grasshopper*.
- 1884 April: First signs of hemoptysis. Graduates, begins medical practice, and publishes his first collection, six short stories, *The Tales of Melpomene*.
- 1886 January: Another volume of stories, *Motley Tales*. February: Begins contributing regularly to the daily *Novoye Vremya* (New Times).
- 1887 Summer: Visits Taganrog. Publishes two more collections, *Twilight*, and *Innocent Words*.
November 19: Premiere of his first play, *Ivanov*, in Moscow.
- 1888 January: Travels extensively in the Crimea and Caucasus.
March: First time to appear in the respectable monthly, *The Northern Messenger*, with "The Steppe."
October: Awarded the Pushkin Prize by the Academy of Sciences.
- 1890 April: Leaves Moscow for Sakhalin, arrives July 11, and spends three months there. *Gloomy People*, his fifth collection, appears.
- 1892 January: Organizes relief for famine victims in Nizhny-Novgorod and Voronezh.
February: Buys his Melikhovo estate near Moscow and lives there with his parents.
Summer: District supervisor during impending cholera epidemic.
- 1893 Contributing to *Russkaya Mysl'* (Russian Thought), which formerly cen-

sured him for "lack of ideas." "War No. 6" published in November edition.

- 1895 June: *The Island of Sakhalin* appears in book form, previously serialized in *Russian Thought* and *New Times*.
August: First visit with Tolstoy at his estate, Yasnaya Polyana.
- 1894- Organizes and partially finances construction of three schools in Melikhovo and two neighboring villages.
- 1897 October 17: Premiere of *The Sea Gull* is a fiasco.
- 1897- March: Severe pulmonary hemorrhage. Spends next year in Nice, where he follows the Dreyfus case, siding with Zola.
- September: Relinquishes medical practice on doctors' advice and moves to his new estate in Yalta.
- December 17: First performance of *The Sea Gull* by the Moscow Art Theater is a huge success.
- 1899 Sells all rights, except those of plays, to A. F. Marx for 75,000 rubles. Ten volumes of collected works appear 1899-1901.
October 26: Premiere of *Uncle Vanya* at the Moscow Art Theater.
- 1900 January: Elected, with Tolstoy, an honorary member of the Section of Belles Lettres of the Academy of Sciences.
- 1901 January 31: Premiere of *The Three Sisters* at the Moscow Art Theater.
May 25: Marries Olga Knipper.
- 1902 Health rapidly deteriorating.
September: Resigns fellowship in the Academy of Sciences in protest against Maxim Gorky's removal.
- 1903 December: "Betrothed," his last story, is published in *The Magazine for All*.
- 1904 January 17: Premiere of *The Cherry Orchard* at the Moscow Art Theater.
June 3: Goes with Olga to Badenweiler, a health resort in the Black Forest in southern Germany.
July 2: Dies at Badenweiler, at 3 a.m.

in the Hotel Sommer. Buried in Moscow one week later.

33 November 16: Exhumed and reburied in the section of the Novo-Devichy cemetery reserved for actors of the Moscow Art Theater.

MENTION the name Anton Chekhov and most people think of a man who, with Ibsen, was a cornerstone of modern realistic drama, a short story writer nonpareil, and, above all, a writer able to capture faithfully, like the *camera lucida*, the responses of a man to his life's situation. Perhaps only a *cognoscento* would consider Chekhov the physician. Medicine and literature often seem an incompatible combination; yet Chekhov was able to unite them in a harmonious bond. He once confessed to a fellow medical alumnus that he suffered from "autobiographophobia," but in a rare profile he wrote for the commemorative album of his fifteenth reunion he clarifies this bond:

I don't doubt that the study of the medical sciences seriously affected my literary work; they significantly enlarged the field of my observations, enriched me with knowledge, the true value of which for me as a writer can be understood only by one who is himself a physician; they also had a directive influence and probably because I was close to medicine I avoided many mistakes. . . . I tried, wherever possible, to bring my writings into harmony with scientific data, and where this was possible, I preferred not to write at all. . . . I do not belong to the fiction writers who have a negative attitude toward science, nor am I one of those artists who think that they can arrive at everything by intellect alone. I could not want to be one of them (October 1, 1899)¹

He wrote to his older brother Alexander in January, 1887, that "besides medicine, my wife, I have also literature, my mistress, but I do not mention her—those living in sin will perish sinfully." He repeated this to Ivorin in September of 1888, appending "when I grow weary of me, I pass the night with the other. This may be disorganized, but it is not boring, and besides, neither of them suffers because of my infidelity."

His stories, letters, telegrams and notebooks are sprinkled with references to medical matters, which make Chekhov's writings an interesting chronicle not only of his own tuberculous illness but of European medicine during the final decades of the 19th Century and

the start of the 20th. Moreover, through Chekhov's apolitical eyes, they record the stagnant social atmosphere and political instability following the assassination of Alexander II — "a flabby, sour, dull time." Finally, they follow the growth of the developing art and culture of Russia, offering sketches of its innovators: Stanislavsky's and Nemirovich's founding of The Moscow Art Theater; Diaghilev's Ballet Russe; the paintings of Levitan; Maxim Gorky's "decadent literature"; and Tolstoy's philosophy.

Chekhov was a prolific writer in an epistolary society. The output of his 24-year literary career was published in 22 censored volumes in 1944 by the Council of the People's Commissars. It contains more than 600 stories, his six plays, hundreds of comic sketches and eight volumes of nearly 4,200 letters, telegrams and trivial notes. Although an ardent lover of the verbal economy of telegrams, Chekhov would probably laugh at this sacred keeping of the insignificant. The Chekhov archives of the Lenin Library in Moscow house over 7,000 letters addressed to him.

It is, thus, easy to see how Chekhov's medical career is overshadowed by the calibre and sheer magnitude of his literary genius. Most, if not all, who write about Chekhov — including physicians writing for various journals — emphasize his stature as a writer and provide a paucity of information on Chekhov as a physician. This is understandable, since such information is scattered about and no definitive medically-oriented biography exists (although one thesis reportedly honors Chekhov's role in the history of Medicine²). This paper is in four parts. The first three comprise a biographical sketch of Chekhov the doctor, which has been culled from various sources,³⁻⁹ mainly from his own voluminous writings. The fourth part presents doctors from Chekhov's fiction and suggests how they reflect the attitudes, emotions and life of their creator.

BEGINNINGS

Anton Pavlovich Chekhov was

born on January 17, 1860, in Taganrog, an important port on the Black Sea in southern Russia. He descended from stalwart peasant stock. His paternal grandfather, Yergor, had taught himself to read and write, and through industrious saving was able to buy freedom for himself and his family in 1841. This was 20 years before the general emancipation of serfdom, and cost him 3,500 rubles, then equal to roughly \$1,750. Despite such a humane gesture, Yergor, as a parent, was tyrannical, a trait certainly inherited by Pavel Yegorovich, Anton's father.

In a rare, revealing moment Chekhov wrote to his brother Alexander: "I remember that my father began my education, or rather my beatings, when I was not yet five. Every morning when I awoke, my first thought was: 'Am I going to be beaten today?'" After this dreadful degradation he was obliged to kiss the hand that struck him. A psychiatrist would revel in a retrospective analysis of Pavel Chekhov. Outwardly cruel to his family, he was a religious fanatic, an artist of holy pictures, a self-taught and accomplished violinist and the town historian. He kept a "ship's log" in ornate handwriting, reporting on civic activities, household visitors, the weather and the like. His piety, which he compelled his family to share, was not so much genuine religious devotion as a love of the mysticism, ritual and ceremony of religious services. He constantly prayed before the many icons placed throughout his home and shop, both heavy with the scent of burning incense. In all he did, the vainglorious Pavel Chekhov strove for status, position and respect in his small town.

When other children were playing, the young Chekhovs were in church — either attending services or rehearsing late at night in the choral group formed by Pavel. On Sundays and holy days the children were dragged to church in the early morning to prepare for the morning services:

When I recall my infancy it seems to have been hideous. I have no religion now. When my brothers and I sang in the church everyone looked at us with admiration and

envied our parents, but we felt like veritable prisoners (March 9, 1892).

Later, the religious service was repeated at home, and when the bells rang for the second mass, everyone had to rush back to church. It is no wonder that in his adult life Chekhov admitted to automatically walking faster when he passed a church, "seized with terror."

Perhaps the tenor of Chekhov's youth is captured best in a letter to his publisher Suvorin, in which he discusses an author's need for "personal freedom":

What writers of noble birth took from nature for nothing, commoners purchase at the cost of their youth. Write a story, do, about a young man, the son of a serf, a former grocery boy, a choir singer, a high school pupil and university student brought up to respect rank, to kiss the hands of the priest, to bow to the ideas of others — a young man who expressed thanks for every piece of bread, who was whipped many times, who went without galoshes to do his tutoring, who used his fists, tortured animals, was fond of dining with rich relatives, was a hypocrite in his dealings with God and men, needlessly, solely out of a realization of his own insignificance — write how this young man squeezes the slave out of himself, drop by drop, and how, on awaking one fine morning, he feels that the blood coursing through his veins is

no longer that of a slave but that of a real human being (January, 1889).

Chekhov found his release through wry humor. He had no equal in devising jokes on teachers or imitating the pomposity of town aldermen. In 1873 he discovered an adult game — the theater, which the school viewed as a temple of perdition. With the aid of horsehair sideburns and dark glasses (he was fond of costume and makeup), he sneaked past the school proctor many times to sit in the gallery of the Petrovskaya Street Theater to see such works as *Hamlet*, Gogol's *The Inspector General*, melodramas, French romantic pieces and even an adaptation of *Uncle Tom's Cabin*. Soon, Anton established his own theater, manned by siblings and friends. Their first production was Chekhov's own satiric version of *The Inspector General* in which he himself played the pompous mayor. Complete with a three-pillow abdomen and a chest blazoned with cardboard medals, this lonely youth had the audience rolling in the aisles

— making others laugh at what had made him suffer.

Pavel Chekhov's business collapsed in 1875, and he absconded to escape debtor's prison. The family moved to Moscow, leaving Anton behind. During his years at the *gymnazium* he launched his literary career with a satirical magazine in manuscript, which he called *The Stammerer*. This same year is also cited by his biographers as that during which Chekhov first became interested in medicine. He had contracted what was probably tuberculous peritonitis after swimming in an icy river, and it was due only to the efforts of the school physician, a Russian-German named Strempf, that Chekhov survived. Supposedly Strempf encouraged the boy to study medicine. Chekhov later claimed that he had only the vaguest notions about the medical faculties and did not remember what prompted him to go into medicine, but affirmed that he never regretted the choice.¹⁰

(to be continued)

Nobody sees people as they are and finds the chance to help poor humanity as a doctor does. The decorations and deceptions of character must fall away before the great realities of pain and death. The secrets of many hearts and homes must be told to this confessor, and sadder ailments than the text-books name are brought to be healed by the beloved physicians. Teachers of truth and givers of the laws of life, priests and ministers,—all these professions are joined in one with the gift of healing, and are each part of the charge that a good doctor holds in his keeping.—*A Country Doctor*, Sarah Orne Jewett, 1884, p 342.

Editorials

GET THE BULLET

If a disease of diverse etiology had an attack rate of five in 100,000 in 1961 and a 106 percent increase were observed 14 years later;¹ if the loss of 10,000 lives could be attributed to a single cause in 1974 and if the morbidity rate were much higher, the American public would give generously in time, talent, and dollars, would write congressmen deploring their failure to do something about the problem and would generally be outrageously affronted.

If the disease were murder and one of the causes, the handgun, were the vector in 10,000 deaths, about 10 percent of total deaths resulting from the disease annually, what should the reaction of the public and of our own subset, the medical profession, be? If opinion polls show 70-80 percent of the populace to support some sort of effective regulation,² what should the reaction of congress be?

The National Rifle Association, long the bell-weather of those against regulation, "opposes any proposed legislation, at any level of government, which is directed against the firearm rather than against the criminal misuse of firearms."³ The NRA seems to think that any legislation against the firearm infringes upon the rights of sportsmen, collectors, and those who want or need protection against others who may attack them with firearms or without. Now the NRA has some justification for its position—the frontier myth, the increase in crime rates necessitating more effective means of personal protection, the generally responsible behavior of sportsmen using guns, the historical value of gun collections, constitutional strictures against limitations of bearing arms and so on. However, if the medical profession were to support legislation directed only against the organism rather than concern itself with carriers, we might still be wailing because nothing was being done about Typhoid Mary⁴ and contaminated water supplies.

The quotation cited above was published recently in *Time*³ as part of comment by the executive vice-president of the NRA on a cover story "Crime—Why and What to Do" in an earlier issue.¹ The next letter from a lady in New York State asked "Why not sell revolver bullets in the same way we sell dangerous drugs, by prescription only and in strictly limited amounts?" This makes sense and should satisfy the NRA. After all, it is not the firearm that we would be legislating against but the criminal user who loads it. Without the syringe and the needle, modern medicine

would be paralyzed. It is who loads the syringe, what he puts in it, and how he uses it that counts.

Remember that in western movies and television serials the remedy to gunshot wounds, no matter their sites or seriousness, the approved and heroic therapy is "get the bullet."

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MALPRACTICE IN FOCUS

Although most members of the society will have learned from President Davis' August 5 letter of the actions of the executive council at a meeting called to consider professional liability insurance July 20, further comment may be appropriate. It may seem to many readers that more definitive actions could be taken more quickly so as to relieve the profession of uncertainty which at times amounts almost to mystery about where we stand on our professional liability coverage. Yet orchestration rather than an aria sung by an impetuous prima donna is required because state and federal governments, insurance companies, lawyers and patients are all concerned and a working system must be fair to all, financially sound and responsive to constructive criticism. For those of you who may have missed it, a review of the AMA source document, "Malpractice in Focus," should be helpful in further clarifying the problems and appreciating the efforts being expended at many levels in developing a system which is more flexible and responsive than our present somewhat haphazard arrangements.

If any of you did not receive a copy of "Malpractice in Focus," prepared by the editors of *Prism*, it may be obtained from the order handling department of the AMA, 535 North Dearborn Street, Chicago, Illinois 60610. The prices are \$1 each for up to ten copies, \$.75 each if 11 to 49 copies are required and \$.50 each for orders of more than 50 copies.

While the publication may suggest the physicians and patients in North Carolina have been more fortunate and less harassed than others in this country, we should not take this as indicative of the future. The actions taken at the executive council meeting provide reassuring evidence that the state society is not doing this. We will await with interest the "model bill of desired legislation on the matter of professional liability insurance" which substitute was presented at the September meeting of the executive council.

Emergency Medical Services



EMERGENCY MEDICAL SERVICES: AS IT GOES, SO GOES THE HEALTH SERVICES SYSTEM

Alan S. Kaplan, M.D., M.P.H.
Interim Chairman
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The Health Services System, while still a cottage industry, is this nation's second largest industry equal to roughly 7% of the gross national product. It is clearly checkered with major deficiencies and gaps which result in inadequate and incomplete care. Nowhere is this more pronounced than in the subsystem of Emergency Medical Services (EMS). Yet it is precisely in this subsystem that great changes can be made which will not only benefit the patient directly, but lead to modernization of the entire industry.

An emergency medical situation—be it an auto accident or a heart attack—is a frightening, bewildering situation to the patient and to his family. It represents a major stress for the physician in terms of disruption of a busy office, a crowded hospital schedule or a much needed night's sleep. Both physician and patient want an emergency medical services system that can meet their needs with the least amount of anxiety and maximum amount of high quality care.

The Emergency Medical Services subsystem is the ideal phase in which to begin making positive changes in the Health Care System. The necessary components for planning are involved, namely; the physician and the patient.

Planning and establishing the subsystem represents all the challenges of establishing any health care system, only in miniature. It requires that the providers, the payors, the consumers, the politicians, the patients and the press be involved—as they would be in establishing a health care system. It provides an opportunity for them to begin to work together—to learn to trust one another—to cooperate in a clearly definable area of the health care system without too much of the dangers that would be needed in a larger venture. It is an area in which they can see, feel and hear tangible results. It is an incubator in which they can grow together to conquer greater challenges—the establishment of a modern health care system.

Physician cooperation is essential in developing the Emergency Medical Services System. Physicians, as their work loads increase, as their demands for time are heightened, as their wants for greater leisure and family time are accentuated, need a well organized, comprehensive, high quality Emergency Medical

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE

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San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

Services (EMS) system. Such a system will free them from disruption of their normal work schedule, while at the same time assuring 24 hour patient care. Further, physicians recognize that the definable area of EMS is one within which they can clearly cooperate knowing that their medical decisions and the physician/patient relationship are not to be subverted by non-medical personnel and governmental regulations. EMS is an area where real physician cooperation and contribution can occur. (And quite probably the only area at present.)

EMS, furthermore, is an area of acute concern to the consumer/patient. In an acute illness—where the need for health care is great—there is no time to wait—to choose—to call multiple numbers—to make an appointment. With house calls at a minimum, the need for acute life support is only available now through well trained Emergency Medical Technicians and properly equipped ambulances. The longer the

television program "Emergency" is on the air, the greater is the chance for higher public demand.

Finally, EMS has great public visibility. The public easily recognizes siren blowing, red lighted ambulances. Millions of dollars for research are only a concept—and beyond the realistic concept of most. The EMS system provides tangible, visible, audible evidence of a program at work.

Thus the modernization of the EMS can lead to the cooperation, trust and proof that efforts aimed at improving the health care system can be meaningful and lead to improved patient care.

From "Emergency Medicine Today," Vol. 4, No. 6, June, 1975. John H. Howard, M.D., Editor. Original article may be obtained from the Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Bulletin Board

NEW MEMBERS of the State Society

Adams, Gerald Leon, MD (RENEWAL), 5900 Eastbrook Rd., Charlotte 28215
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 Ari, Abdullah Necip, MD (OBG), 824 S. Aspen St., Lincolnton 28092
 Baker, John Woodward, MD (EM), 2415 Tanglewood Lane, Charlotte 28211
 Brewster, Vann, MD (OM), Apt. #1, Chateau Terrace Apts, Wilmington 28401
 Cox, George Franklin, Jr., MD (FP), Ste. 101, 4000 Park Rd., Charlotte 28209
 Davis, Walter Etchells, MD (HEM), Duke Med. Ctr., Hem. Div., Durham 27710
 Diaz-Buxo, Jose Antonio, MD (IM), 2313 Lathrop Ln., Charlotte 28211
 Dove, Francis Bernard, Jr., MD (RHU), 1350 S. Kings Dr., Charlotte 28207
 Finn, William Francis, MD (IM), UNC, Dept. of Medicine, Chapel Hill 27514
 Giragos, John, MD (RENEWAL), 3325 Chapel Hill Blvd., Durham 27707
 Hadler, Nortin Marvin, MD, UNC, Dept. of Med., Chapel Hill 27514
 Hall, Colin David, MD (N), UNC, Dept. of Med., Chapel Hill 27514
 Jan, Gwang Soo, MD (OBG), University Heights, Cullowhee 28723
 Jarden, James Benford (STUDENT), 313 Carlton Dr., Chapel Hill 27514
 Jordon, Robert Marshall, MD (FP), 3412 Wembley Court, Raleigh 27607
 Hunter, William Bridges, III, MD (P), N. C. Memorial Hospital, 5200 Psychiatry, Chapel Hill 27514

Jacinto, Romulo C., MD (IM), 130 Rawley Ave., Mt. Airy 27030
 James, Charles Greene, MD (IM), 951 S. Independence Blvd., Charlotte 28202
 Kihlstrom, Bruce Lee, MD (INTERN-RESIDENT), 2445 Springview Trail, Chapel Hill 27514
 Kramer, Judith Mae (STUDENT), 1133 Pittsboro Road, Chapel Hill 27514
 Kroncke, Frederick George, Jr., MD (OBG), 305 Southern Blvd., Rocky Mount 27801
 Lewis, Harry Michael, MD (INTERN-RESIDENT), Box 3307, Duke Medical Center, Durham 27710
 Maness, Rubin Franklin (STUDENT), 815 Pittsboro Rd., Chapel Hill 27514
 Markham, Thomas Carl (STUDENT), 3521 Windsor Dr., Charlotte 28209
 Moress, Ralph Louis, MD (P), P.O. Box 1406, Fayetteville 28304
 Ocampo, Teresito Paras, MD (P), 217 W. Wilson St., Smithfield 27577
 Pennink, Menno, MD (NS), 507 Sandhurst Dr., Fayetteville 28304
 Pillsbury, Harold Crockett, III, MD (INTERN-RESIDENT), 54 Red Pine Road, Chapel Hill 27514
 Pruett, Dennis Derwood, MD (EM), 101 Lamplighter Circle, Winston-Salem 27103
 Ravenet, Louis, MD (PN), 143 Providence Sq. Dr., Charlotte 28211
 Sarubbi, Felix Anthony, Jr., MD (ID), N. C. Mem. Hosp., Chapel Hill 27514
 Smith, John Braswell, Jr. (STUDENT), Apt. 27, Holland Dr., Chapel Hill 27514
 Spahr, John, MD (INTERN-RESIDENT), 1315 Morreene Rd., Apt. 31-H, Durham 27705
 Steiner, Michael Lee, MD (OPH), 165 Winstead Ave., Rocky Mount 27801
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 Utsinger, Peter Devlin, MD, UNC, Dept. of Medicine, Chapel Hill 27514
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 Whitlock, Cary Thomas, III (STUDENT), 932½ N. Greensboro St., Carrboro 27510

Williams, Lynne Huie, MD (PD), 146 Victoria Road, Asheville 28801
 Wilson, Larry Allan (STUDENT), 9-G Royal Park Apts., Carrboro 27510
 Wood, Phillip Charles (STUDENT), P. O. Box 804, Chapel Hill 27514

WHAT? WHEN? WHERE? In Continuing Education

October 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician's Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

October 17-18

Seventh Annual Duke Symposium on Orofacial Anomalies
 Credit: 12 hours; AAFP credit applied for
 For Information: Raymond Massengill, M.D., Department of Surgery, P. O. Box 3523, Duke University Medical Center, Durham 27710

October 17-18

Office Management of Marital and Sexual Problems
 Fee: \$100 (includes spouse)
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

October 17-19

NCSIM 1975 Annual Fall Meeting
 Place: Sugar Mountain Resort, Banner Elk
 For Information: Mrs. Jackie Cutrell, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

October 20-24

Endocrinology and Metabolism Symposium
 Sponsors: Department of Medicine, Duke University Medical Center, and the American College of Physicians
 For Information: Harry McPherson, M.D., Box 3006, Duke University Medical Center, Durham 27710

October 24

"Priorities in the Treatment of Patients with Multiple Injuries,"
 Moore Memorial Hospital Continuing Education Series
 Place: Country Club of Southern Pines (Elks Club)
 Sponsor: Moore Memorial Hospital; UNC School of Medicine
 Fee: \$11.50
 Credit: 2 hours; AMA Category I and AAFP approved
 For Information: C. H. Steffee, M.D., P. O. Box 3000, Pinehurst 28374

October 30

Diagnosis and Treatment of Sleep Disorders
 Credit: 2 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 3-7

Current Concepts in Pediatric Radiology
 Place: Pinehurst Hotel, Pinehurst
 Program: There will be a systems oriented format covering Cardiopulmonary diseases on Monday; Gastro-intestinal diseases on Tuesday; Genito-urinary diseases on Wednesday; Musculoskeletal diseases on Thursday; "with Friday left for miscellaneous disorders."
 Credit: 25 hours
 For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

November 7

Scientific Session, Alumni Association, Bowman Gray School of Medicine

Credit: 5 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

November 13-14

Nurse Participation for Health Planning
 Place: Velvet Cloak Motel, Raleigh
 Sponsors: The North Carolina League for Nursing and the UNC School of Public Health, Department of Continuing Education
 Fee: NCLN members \$16; non-members \$26. Enrollment limited to 150

Credit: CERP and CEU
 For Information: Ms. Cindy Stubblefield, Continuing Education, School of Public Health, UNC, Chapel Hill 27514

November 21-22

Second Annual Arthritis Symposium
 Fee: \$35
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 5-6

Family Practice Workshops
 Credit: Credit hours have not yet been determined
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 6-7 (Note change of date)

Endoscopy Workshop
 Place: Berryhill Hall
 Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine
 Fee: \$75
 For Information: John T. Sessions, Jr., M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

December 13

Annual Staff Meeting, Department of Ophthalmology, North Carolina Memorial Hospital and McPherson Hospital
 Place: UNC School of Medicine Clinic Auditorium
 Sponsors: UNC School of Medicine, Department of Ophthalmology, and McPherson Hospital
 Credit: 8 hours
 For Information: Samuel McPherson, Jr., M.D., Department of Ophthalmology, UNC School of Medicine, Chapel Hill 27514

December 13

Epilepsy Workshop
 Place: 103 Berryhill Hall
 Fee: \$10
 Credit: 7 hours; AAFP credit applied for
 For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

December 13

Geriatric Medicine for the Practitioner
 Place: Duke Hospital Amphitheatre
 Sponsors: Duke University Center for the Study of Aging and Human Development; American Geriatrics Society; Duke Family Practice Clinic
 Fee: \$35; registration limited
 Credit: 6 hours; AAFP credit applied for
 For Information: Dorothy Heyman, Executive Secretary, Center for the Study of Aging and Human Development, Box 3003, Duke University Medical Center, Durham 27710

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient
 Fee: \$100
 Credit: 15 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 30-31

Conference for Medical Leadership
 Place: Royal Villa Hotel, Raleigh
 For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P. O. Box 27167, Raleigh 27611

February 11

Wingate M. Johnson Memorial Lecture
Place and time: Babcock Auditorium, 11:00 a.m.
Speaker: Dr. Grant Liddle, Professor and Chairman, Department of Medicine, Vanderbilt University School of Medicine
Credit: 2 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 5-6

Refresher Course in General Radiology
Fee: \$100
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 22-26

Radiology of the Urinary Tract—a Tutorial Postgraduate Course
Program: Emphasis on personalized small group tutorial type teaching. Subject matter will cover all facets of urinary tract disease, including comprehensive coverage of diagnostic techniques
Fee: \$300
Credit: 30 hours
For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 25-26

Medical Alumni Day and Scientific Meetings
Place: Berryhill Hall
Sponsor: Office of Continuing Education and Alumni Affairs
Credit: To be announced
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 26

Symposium on Alcoholism
Fee: \$25
Credit: 6 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 29-30

Obstetrics and Gynecology Postgraduate Course
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 9-10

Practical Pediatrics
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 10-11

Annual Arthritis Symposium
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 16-17

Practical Nuclear Medicine: Emphasis Oncology
Fee: \$75
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 23-24

Diving Deafness and Related Physiology
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 23-24

Perinatology Post-Graduate Course
For Information: Oscar L. Sapp, III, M.D., Associate Dean for

Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 23-30

Medical Symposium—Cruise to Bermuda
Sponsors: Bowman Gray School of Medicine and the Medical University of South Carolina
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

ITEMS OF SPECIAL INTEREST

November 3-8

Course in Laryngology and Bronchoesophagology
Program: Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.
For Information: Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association
Place: Houston Oaks, Houston, Texas
Program: Post-graduate courses offered as part of the meeting will include: Basic Fetal Monitoring; Children's Orthopaedics; Gastroenterology; EKG Morphology of Peripheral Blood Smears and Bone Marrow Sections; Diagnosis and Treatment of Platelet Disorders; Prevention and Control of Hospital-Associated Infections; Respiratory Therapy; Hypospadias, Epispadias, Peyronie's Disease, and Other Conditions Causing Penile Curvatures; Advanced Fetal Monitoring; New Developments of Detection, Treatment, and Follow-Up of Gynecologic Malignancies; Office Management of the Infertile Couple; Hand Surgery (Part I and Part II); Pediatric Urology; Pediatric Dermatology; Dermatology for Non-Dermatologists; Functional Cast Bracing; and Disorders of Fluid, Electrolyte, and Acid-Base Balance.
Credit: All courses are approved for hour-for-hour AMA Category 1 credit
For Information: Southern Medical Association, 2601 Highland Avenue South, Birmingham, Alabama 35205

The 1975 Revised North Carolina Dietetic Association's Diet Manual as well as revised diet pages for those who already have the manual are now available. The cost of the manual is \$10.40; the packet of revised pages is \$2.60.
For Information or to order: Karen C. Hauersperger, NCDA Executive Secretary, 5836 Gate Post Road, Charlotte 28211

Continuing Education for Nurses

For information on the following continuing education opportunities, write to Judith Wray, Administrative Secretary, Continuing Education Program, UNC Chapel Hill School of Nursing, Chapel Hill 27514
October 21: Practical Approach to Drug Interactions. Fee \$30. Enrollment limited to 32 participants
October 30-31: Family Centered Maternity Care. Fee \$50 for 2 days; may choose to attend for one day only
November 6-7: Nursing Audit. Fee \$50
November 10-11: The Nurse: Planning Classes for Expectant Parents. Fee \$75
November 17-21: Nursing Process. Fee \$112
James M. Johnson Awards are available to assist in covering the costs of the above workshops.

UNC Medical Alumni Association District Meetings

October 22—District 6
Holiday Inn, Wrightsville Beach
November 11—District 15
Salisbury Country Club, Salisbury
December 10—District 12
Greensboro City Club, Greensboro
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

PROGRAMS IN CONTIGUOUS STATES

October 16-17

The 47th Annual McGuire Lecture Series—a Postgraduate Course in Common Problems in Dermatology
Sponsors: Department of Continuing Education and Department of Dermatology
Fee: \$95

Credit: 10 1/2 hours: AMA Category I; AAFP credit applied for
For Information: Department of Continuing Education, School of
Medicine, Medical College of Virginia, Box 91, MCV Station,
Richmond, Virginia 23298

October 20-21

Tennessee Valley Medical Assembly annual meeting
For Information: Clifton R. Cleaveland, M.D., Tennessee Valley
Medical Assembly, Whitehall Medical Center, 960 East Third
Street, Chattanooga, Tennessee 37403

November 13-15

Adolescent Medical and Social Problems
Place: Baruch Auditorium
Sponsors: Department of Continuing Education and the Section of
Adolescent Medicine, Medical College of Virginia
Fee: \$80; enrollment limited to 270 participants
Credit: 15 hours; AAFP approved; approved American Academy
Pediatrics
For Information: Dr. George M. Bright, Director of Adolescent
Medicine, Box 151, Adolescent Clinic, Medical College of Vir-
ginia, Richmond, Virginia 23298

December 7-10

Structure-Function Correlations in Cardiovascular Disease
Place: Williamsburg Conference Center, Williamsburg, Virginia
For Information: Miss Mary Anne McInerney, Director, Depart-
ment of Continuing Education Programs, American College of
Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN?
WHERE? P. O. Box 8248, Durham, North Carolina 27704, by the
10th of the month prior to the month in which they are to appear.

AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

This summer, I spent two weeks in the British Isles. One week was spent exploring London while my husband attended the Royal Society of Medicine conference on sexually transmitted diseases and the second roaming the countryside from south of London to Edinburgh and Glasgow and then back down through the Lake District and the Cotswolds (Shakespeare country). The beauty of England and Scotland is unsurpassed anywhere; the charm is irrefutable; the history is exciting to even the most blase of travelers. There is, however, one very jarring aspect to the country today. With all that it has and all that it has had through the centuries, today there is an atmosphere of desperation, crisis and doom because of the economic situation in which the country presently finds itself.

Instead of easing taxation and increasing spending power in order to get the economy moving again, the government continues to tax on the middle and upper classes almost to the breaking point. Even so, there are not enough revenues for the National Health Service. Instead of this institution emerging a model of efficiency and excellence with all the monies which have been poured into it over the past 27 years, it is reportedly "gravely ill." Very few people are at all satisfied with their cradle to the grave free health care. Those who are financially able, still seek private medicine when the chips are down. Even the members of Parliament who academically denounce the last surviving remnants of private practice are very much inclined to go to the surgeon in the private sector when

it comes time for an operation. They are wary of signing a document before being put to sleep and under the knife which states they do not know who is to operate—"nor does it matter!"

The auxiliary to the North Carolina Medical Society is concerned about the future of private practice in this nation and in this state. More and more, it has made itself aware of what is happening in our government to affect the practice of medicine in the United States. The auxiliary knows it can be a powerful force against inroads which can lead to a situation not unsimilar to the one in the British Isles. A government take-over of medicine is *not* inevitable. The United States does not have to end up with the tail wagging the medical dog as is often the case elsewhere.

The auxiliary keeps abreast of state and national legislation pertaining to medicine, and speaks out against abuses. The auxiliary is learning that it can suggest and promote legislation which is beneficial to doctors and to the communities. The auxiliary, through contributions to the AMA Educational Research Fund (AMA-ERF) also is instrumental in financing the education of prospective doctors in these expensive times to assure enough numbers to maintain the quality of medicine this country has enjoyed for so many years.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

A free cancer screening program began this fall for employees of Cannon Mills Plant 4 in Kannapolis.

The program is sponsored by Cannon and Duke's Comprehensive Cancer Center. It marks the first time an industry has teamed up with the Cancer Center to bring cancer detection services to people where they work.

Men 35 and older are invited to undergo tests for prostate and rectal cancer. Smokers will be checked for oral cancer; men 45 and older who smoke will be given a chest X-ray for lung cancer.

Women 20 and older are invited to have a Pap smear taken. Examinations for breast cancer and rectal cancer also are offered to women 35 and older.

Men and women screened are asked to bring in urine samples which nurses check for signs of bladder cancer and diabetes.

Finally, all who participate will have their blood pressure measured.

Every employee screened is sent a letter with the results of the tests. If additional tests are needed, employees are referred to their personal doctors.

Cannon Mills pays for all Pap smears as well as for urine and rectal cancer test strips.

All screening tests are done in the plant infirmary by a doctor and a nurse from the Cancer Center, and nurses from the plant infirmary. The Duke physician, Dr. Siegfried Heyden, said the program is held in the

plant to make participation as easy as possible for employees.

"It's much more convenient to conduct a program like this at the place of work," he said, "rather than ask workers to come to the doctor." "The Cabarrus County Medical Society voted unanimously to support the effort," he said.

Heyden, director of the Cancer Control Program here, won an award from the German Medical Society for setting up similar screening plans in Switzerland.

* * *

An interview involving three Duke physicians was the subject of an article in the August issue of *Nation's Business*, a monthly publication of the Chamber of Commerce of the United States.

The article was titled, "Feel Better, Live Longer, and Work Like a Horse," and deals with the health of business executives.

Interviewed for the question-and-answer article were Dr. E. Harvey Estes, chairman of the Department of Community Health Sciences; Dr. Redford B. Williams, Jr., assistant professor of medicine and psychiatry; and Dr. Woodhall Stopford, assistant professor of community health sciences.

The story grew out of a lengthy taped discussion earlier this year between the three physicians and Sterling Slappey, the magazine's senior editor.

The Duke Endowment and the Nanaline H. Duke Trust of New York have made an \$11-million commitment to the university for the financing of the new \$96.3 million Duke Hospital North.

Construction of the 616-bed facility began in September.

Trustees of the Duke Endowment have approved support of as much as \$8 million over the next several years. Another \$3.3 million has been made available by the Nanaline Duke Trust.

These grants provide the university with the necessary minimum equity funds of \$30 million to proceed with construction, a minimum established last May by the university trustees. The remainder of the construction costs is being raised through sale of bonds.

* * *

Duke carpenters have disassembled the medical school library's historic Trent Room and have reassembled it in the heart of the new Seeley G. Mudd Building which will house the medical library when it opens later this year.

The lumber which makes up the Trent Room is both delicate and expensive. It was brought to Duke in the middle 1950s to provide a suitable home for Duke's sizeable collection of rare medical books. At the time the paneling was already 230 years old.

An English carpenter removed the paneling from a

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WILLIAM D. KERNODLE, M.D.

house in the south of England. The stately structure, built in 1725, was being torn down and Mrs. James H. Semans saved a part of it by having it brought to Duke.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The Bowman Gray School of Medicine and the Human Performance Laboratory of Wake Forest University will play a major role in the development of a comprehensive rehabilitation program for victims of cardiovascular disease in North Carolina.

The program is supported by a \$916,463 grant to the North Carolina Heart Association from the North Carolina Division of Vocational Rehabilitation Services.

The heart association has contracted with Bowman Gray and the Wake Forest laboratory to develop the program, which will include rehabilitation while the patient is still hospitalized, counseling and exercise rehabilitation after the patient returns home, help in evaluating what types of work patients can safely do and continuing education for health professionals in cardiac rehabilitation.

The continuing education effort will be done through the Northwest Area Health Education Center, which is directed by the Bowman Gray School of Medicine.

* * *

Dr. Donald M. Hayes, associate dean for community health sciences and professor and chairman of the Department of Community Medicine at Bowman Gray, has been selected an Outstanding Educator of America for 1975.

The selection recognizes his contributions to the advancement of higher education and service to the community. His biography and a record of his ac-

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or phone 803/449-7426

complishments will appear in the 1975 edition of the Outstanding Educators of America Awards Volume.

* * *

Dr. Cornelius F. Strittmatter, professor and chairman of the Department of Biochemistry, has been named to a two-year term on the Council of the Association of Medical School Departments of Biochemistry.

* * *

The Physician's Assistant Program at the Bowman Gray School of Medicine recently graduated 28 students. The program, which opened in 1969, has now graduated 86 students, most of whom are working with primary care physicians in North Carolina.

A new class of 40 students began studies in the program in September. Forty people in each class is the maximum enrollment intended for the program.

* * *

Dr. James G. McCormick, associate professor of otolaryngology at Bowman Gray, has been awarded a three-year grant for \$164,382 to study the relationship between the development of atherosclerosis and loss of hearing.

The grant is from the National Institute of Neurological Diseases, Communicative Disorders and Stroke.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

The National Cancer Institute has awarded the University of North Carolina School of Medicine at Chapel Hill \$1,230,018 to establish a specialized cancer research center.

Foundations for a variety of Cancer Center programs will be developed during the next three years under the direction of Dr. Joseph S. Pagano, professor of medicine and bacteriology and immunology.

The primary thrust of the Cancer Center at the outset will be directed toward basic laboratory research. Selected areas will be integrated into an interdisciplinary program aimed at developing new approaches to the detection, control and understanding of cancer.

In announcing the award, Dean Christopher C. Fordham, III and Dr. Pagano said much significant cancer-related research and many clinical activities are underway presently on the Chapel Hill campus.

* * *

Drs. Joel B. Baseman and Peter D. Utsinger of the UNC School of Medicine at Chapel Hill have been named Jefferson-Pilot Fellows in Academic Medicine for 1975-76. Each will receive \$2,000 per year for four years.

The fellowship program, established four years ago by the Jefferson-Pilot Corporation, is designed to attract and hold young faculty to the UNC-Chapel Hill School of Medicine by enabling them to "explore new ideas, new ways of teaching students, treating patients or investigating biological problems."

Dr. Baseman, assistant professor of bacteriology and immunology, will study growth control in animal cells. His research will center on the role of specific hormones and other factors in blood plasma responsible for activating and coordinating cell growth.

Dr. Utsinger, assistant professor of rheumatology, will study the interaction between cells in cell-mediated immunity. He will examine lymphocytes from patients with systemic lupus erythematosus (SLE), a close relative of rheumatoid arthritis.

* * *

The departments of bacteriology and immunology and medicine of the UNC School of Medicine at Chapel Hill have been awarded a HEW grant to train individuals for research careers in the field of venereal disease.

The program's goal is to develop scientists whose future careers will be devoted to understanding the biology of the organisms which cause venereal infection and of the host responses to these infections. Several laboratories at the medical school have joined together under the program to form a multi-disciplinary training and research group.

Members of the training group include Drs. G. P. Manire, Priscilla Wyrick, Harry Gooder and Joel Baseman of the department of bacteriology and immunology. Joining them will be Drs. Phillip Sparling and Joseph Pagano, who hold appointments in both departments.

* * *

Dr. Neil Kirkman of the UNC-Chapel Hill has been appointed chairman of the Genetics Study Section of the National Institute of Health (NIH). His appointment is for three years. The section reviews about 300 genetic research grant applications per year and advises the NIH on their scientific merit. The 20-member section meets three times per year.

Dr. Kirkman heads a genetics research laboratory at the Biological Research Center of UNC's Child Development Institute. He is also a professor of pediatrics in the UNC School of Medicine.

* * *

New Faculty

Russell L. Pimmel, associate professor, Departments of Surgery and Medicine, comes to Chapel Hill from Ohio State University where he has been an assistant professor of electrical engineering. He received his B.S. from St. Louis University and his M.S. and Ph.D. from Iowa State University.

James C. Reed, associate professor, Department of Radiology, holds the B.S. from Florida Southern College and the M.D. from the University of Miami. He

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has been chief, division of diagnostic radiologic pathology and thoracic radiologic pathology branch, Armed Forces Institute of Pathology.

Jagmohan D. Gupta, assistant professor, Department of Medicine, spent the past year as a research fellow in cardiology at the UNC School of Medicine. A graduate of the Government Medical College, he received his M.D. from Delhi University, India.

J. Robert Koewing, assistant professor, Department of Medical Allied Health Professions, has been associate director of the UNC at Chapel Hill Area Health Education Center program. He holds the B.A. from Trinity University and the M.Div. and S.T.M. from McCormick Theological Seminary.

Dwight A. Powell, assistant professor, Department of Pediatrics, has been a fellow and part-time instructor at UNC School of Medicine. He holds both the B.S. and M.D. from the University of Illinois.

James D. Thullen, assistant professor, Department of Pediatrics, is a specialist on the newborn infant. Last year he was a fellow at Duke University. He received a B.S. in pharmacy at Ohio Northern University and a D.O. from the College of Osteopathic Medicine and Surgery, Des Moines, Iowa.

Abraham L. Kierszenbaum has been appointed assistant professor in the Department of Anatomy,

School of Medicine. He has been head of the Department of Pathology of Ciudadela Hospital, National Health Department, Argentina and a postdoctoral fellow and part-time instructor in Anatomy at the UNC School of Medicine. A native of Argentina, he holds the B.S. from National College "M. Moreno" Buenos Aires; M.D. and Doctorate of Medical Sciences from the University of Buenos Aires and expects to earn the Ph.D. from the University here in 1975.

Barry R. Lentz, assistant professor, Department of Biochemistry and Nutrition, School of Medicine, has been a visiting scientist at the Weismann Institute of Science, Rehovot, Israel and a postdoctoral fellow and teaching apprentice at the University of Virginia School of Medicine. He holds the B.A. from the University of Pennsylvania and Ph.D. from Cornell University.

Michael R. McGinnis, assistant professor, Department of Bacteriology and Immunology, School of Medicine, comes to Chapel Hill from the South Carolina Department of Health and Environmental Control where he has been chief of the Mycology Section, Bureau of Laboratories since 1974. He holds a B.S. from California State Polytechnic College and Ph.D. from Iowa State University.

Donald Kenneth Mitchell, assistant professor, Department of Medical Allied Health Professions, School of Medicine, has served as Rehabilitation Consultant at Altoona Hospital in Pennsylvania the past year and earlier held similar positions at Charlotte (N.C.) Rehabilitation Hospital and Highland View Hospital in Cleveland. He holds a B.S. from Ohio State University, M.Ed. from Bowling Green State University and Ph.D. from Pennsylvania State University.

* * *

Promotions

New associate professors: Frank Thomas Stritter, Department of Family Medicine, and Ella Gray W. Ennis, Department of Medical Allied Health Professions.

New professors: Michael K. Berkut, Department of Biochemistry; Robert G. Faust, Department of

Physiology; William E. Koch, Department of Anatomy; Gustavo S. Montana, Department of Radiology; and Robert A. Mueller, Department of Anesthesiology.

SCHOOL OF SONIC MEDICINE GROUP STUDENT PROGRAM

A three month postgraduate course of in-residence training in the School of Sonic Medicine of the Bowman Gray School of Medicine of Wake Forest University will cover all aspects of ultrasonic technology, and will provide the student with a background in ultrasonic medicine and techniques. With this experience and knowledge, he can return to his hospital or group and set up an ultrasonic laboratory and training program for technical personnel.

Under the group student program, the professional group would reserve one place in the course and then choose students to attend the various segments according to individual interests or needs, allowing considerable flexibility in attendance and experience. It would also permit several members of the group to become more experienced in different fields of ultrasound.

The basic course in acoustics and instrumentation is strongly recommended for all students. For those unable to attend this portion, material will be available via videotape. Students will be expected to spend extra time familiarizing themselves with this material.

The cost of the entire course will be \$3,500 to the "group student." It will be the responsibility of the group to decide the individual cost on a prorated basis (i.e. a radiologist, cardiologist, neurologist, etc., may split the course if they are from the same location).

The course begins September 22, 1975; for further information write Division of Continuing Education Bowman Gray School of Medicine, 300 South Hawthorne Road, Winston-Salem, North Carolina 27103 or call 919-727-5256, 919-727-4505 or 919-727-4450.

POSTGRADUATE COURSE IN SONIC MEDICINE For the Information of Group Students

Date	Course
Sept. 22-27	Acoustics & Instrumentation
Sept. 29-Oct. 3	A-Mode Scanning—Doppler
Oct. 6-10	AIUM National Meeting (Program & Instruction Courses)
Oct. 13-17	Neurosonology
Oct. 20-24	Urinary Tract—Oct. 20-22 Abdomen—Oct. 23-24
Oct. 27-31	Abdomen
Nov. 3-7	Obstetrics & Gynecology
Nov. 10-14	Radiation Therapy Nov. 10-11 Ophthalmology Nov. 12-14
Nov. 17-21	Adult Cardiology
Nov. 24-28	Adult Cardiology
Dec. 1-5	Adult Cardiology
Dec. 8-12	Pediatric Cardiology

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Solar keratosis is not an uncommon medical problem.

Of course, the prevalence of keratotic lesions is greater in locations south of the 38th parallel—the so-called "Solar Keratosis Belt"—receiving the greatest amounts of solar radiation. However, solar keratosis can occur among any light-skinned population, usually in persons over 40, wherever people are subject to extended exposure to the sun.

Solar keratoses are generally not difficult to identify.

These skin lesions are usually multiple, flat or slightly elevated, brownish or red in color, papular, dry, rough, adherent and sharply defined. They are found on areas of the skin having extensive exposure to sunlight. Clinical characteristics of the lesions, their predominant location on exposed surfaces, the age of the patient and his skin type are important considerations in the diagnosis.

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Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to

respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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pensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris (hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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Month in Washington

Congress deserted Washington for a summer holiday leaving behind not only the August heat of the Potomac swamplands but also most of its planned health legislation still hanging up in the humid air.

With passage of national health insurance (NHI) written off for this year, both the Senate and House on return will tackle a variety of health or health-related matters including health manpower, already passed by the House, amendments to the Health Maintenance Organizations Act (HMO), and possible changes to the Medicare law.

While the health subcommittee of the House Ways and Means Committee has scheduled public hearings on NHI for October 28, subcommittee chairman Daniel D. Rostenkowski (D-Ill.) stated "the considerable lead time needed to forge a NHI bill" as the unexpected reason for hearings this year.

Pressing problems with Medicare, however, have prompted Rep. Rostenkowski to schedule hearings on possible changes to that law on September 19.

"Recent oversight hearings concerned certain HEW regulations, including those on utilization review and the 8½ percent nursing care differential. As we consider Medicare changes, I expect that we will explore the possibility of major modifications in the way hospitals are reimbursed. And we will look at how Medicare may help hospitals facing steep increases in malpractice insurance rates," Rep. Rostenkowski said.

The slating of an additional hearing indicates the subcommittee will probably draft legislation to change some of the present Medicare regulations. There may not be time for final Congressional action this year, but legislation could clear Congress next year.

Many of the revisions the subcommittee members are considering would be welcome to the medical profession.

Listed as one topic of the hearing was the present law's requirement that physicians' Medicare reimbursement be tied to a type of cost-of-living index and geared to the 75th percentile of normal and customary charges. The American Medical Association has challenged the fairness of HEW's proposed index and warned that the regulation could drive increasing numbers of physicians away from assignment. Another hearing subject is "physicians' services reimbursement — possible basic changes in present 'reasonable charge' system."

Two other controversial Medicare regulations are up for review—possible revisions in Professional Standards Review Organizations (PSRO) provisions,

and utilization review requirements for hospitals, the latter under temporary injunction by the federal courts as a result of an AMA court protest.

Other issues to be considered by the subcommittee:

- *Termination of the 8½ percent nursing differential in hospital costs;

- *Redefinition of reasonable cost level for hospitals (90th to 80th percentile and revised hospital classification system);

- *Nurse staffing requirements in rural hospitals (authority to waive certain requirements with respect to nurse staffing requirements in rural hospitals expires on January 1, 1976).

- *Medicare relationship to Federal Employee Health Program (no payment may be made under Medicare, beginning January 1, 1976, for services provided to members of the Federal Employee Plan unless a system of coordination between two programs is developed under present law).

- *Revisions in hemodialysis and kidney transplant provision to improve administration and enhance cost effectiveness.

- *Revisions in home health care provisions.

- *Medicare Part B premium increase provision—correction of technical error in present law which precludes increasing the premiums.

- *Institutional services reimbursement—possible basic changes from the present retroactive reasonable cost reimbursement.

- *Consideration of a specific proposal, with respect to malpractice, to permit hospitals to self-insure and charge such costs to Medicare.

- *Revisions in current coverage of ambulance services.

- *Coverage of pap smears under Medicare Part B.

- *Possible changes in payment methods for physicians' services when patient is deceased.

Similar hearings will get underway in the Senate this fall. The Senate Finance Subcommittee on Health, according to Chairman Herman Talmadge (D-Ga.), plans sessions "to resolve some of the reimbursement and related problems in Medicare and Medicaid, and some of the more arbitrary and inequitable regulations which have been promulgated by HEW."

* * *

A bill relaxing some of the federal requirements for Health Maintenance Organizations (HMO's) to receive federal aid has been approved by the Health

Subcommittee of the House Commerce Committee. The legislation was spurred by the lagging start of the once-vaunted HMO program which has been stalled despite high hopes of backers it would prove popular and become a viable alternative to regular health insurance and fee-for-service.

No full committee action was taken prior to the August recess. Senate committee consideration won't begin until after House action, putting a time squeeze on the bill as far as final action this year is concerned.

The AMA had urged the House Commerce Subcommittee headed by Rep. Paul Rogers (D-Fla.) not to reduce the present HMO program to a subsidy for pre-paid group practice plans.

The Subcommittee bill amended the controversial "dual option" clause in the law that requires employers to give individual workers their choice between an HMO plan and private health insurance. Labor has protested this interferes with collective bargaining. The amendment gives union representatives the right to veto an HMO option, but not to veto a regular health insurance option. Thus, Labor would have power to block an HMO but not to accept one for all employers at the exclusion of fee-for-service health insurance.

The provision averted the danger that labor unions could force all employees in a company to accept a union-formed and/or-controlled HMO.

Another important action was elimination of the present "open enrollment" provision for HMO's, a provision designed to avoid having HMO's able to skim the cream and take only low-risk groups or individuals. However, the subcommittee bill retains present requirements that HMO's, to qualify for aid, must "enroll persons who are broadly representative of the various age, social and income groups within the area it serves. . . ."

The bill allows HMO's to offer as optional rather than mandatory some HMO services and to limit the preventive health services which would have to be offered as basic services.

* * *

Another blow to the belly has been delivered to national health insurance plans relying on Social Security financing. The General Accounting Office, supervisor of federal spending and operations for Congress, reports Social Security's trust funds "face exhaustion in the near future because of increased benefit levels due to inflation, and high unemployment causing reduced contributions. . . ."

According to GAO, projections covering the next 75 years show that the system will also incur a large long-range deficit because of the decreasing birth rate and the rising cost of living.

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Congress will have to approve some of the remedies already suggested by various advisory bodies, including financing of Medicare Part A out of general revenues, the equivalent of adding a new \$9 billion annual spending program. The money saved for Social Security, \$9 billion, would be used to support other Social Security programs, primarily the main retirement disability program. Social Security taxes would not be changed, but federal corporate and income levies presumably would have to furnish an extra \$9 billion.

Unless such steps are taken, General Accounting warned, "there may be no alternative to increasing (Social Security) taxes" or the wage base or both.

* * *

A Federal Court ruling threatens to crimp the Food and Drug Administration's plan to make it easier for "generic drug" makers to market their products quickly after patent protection runs out on brand-names.

An order by U.S. District Court Judge June Green in Washington, D.C., blocked FDA from allowing Zenith Laboratories, Inc., Northvale, N.J., to market a generic version of chlordiazepoxide without first obtaining a new drug application. The ruling was sought by Hoffman-La Roche Inc., Nutley, N.J., which markets the product as Librium.

Judge Green said the NDA requirement for generic drugs has an anti-competitive effect, but "the overrid-

ing interest in insuring the health and safety of the public through compliance . . . requires the result reached here."

Securing an NDA for a product is a lengthy and expensive procedure, requiring test data, etc., and would delay for a long period introduction of competitive "generic" drugs in cases where patents have lapsed.

If upheld by higher courts, the ruling could hurt the HEW Department's controversial Maximum Allowable Cost (MAC) program intended to foster purchase of generic drugs by Medicaid patients. MAC has been challenged in Federal Court by the AMA.

* * *

The Food and Drug Administration heard strong arguments for and against warning labels for oral diabetic drugs at an unusual one-day hearing on one of the Agency's keenest medical-scientific controversies over the past five years.

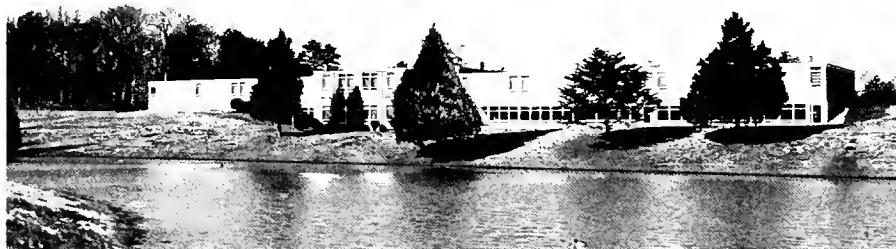
A new British study and the testimony of one of the original American investigators cast some doubt on the validity of the scientific data FDA has been relying upon in its effort to crack down on oral hypoglycemics. On the other hand, one of Ralph Nader's health teams contended the warning label was insufficient and called for written consent by patients taking the oral products.

The hearing was called to further air the differences of opinion on the FDA's proposed warning that there

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may be increased risk of cardiovascular death in diabetic patients treated with the oral drugs. The proposal is based on a 1961-1970 clinical study by the University Group Diabetes Program (UGDP) which claimed that heart disease death rate was twice as high among patients treated with the oral drugs compared with those on insulin or on special diets.

A double blind study by University of London professor Harry Keen suggested evidence of long-term benefits from Tolbutamide and Phenformin and no long-term cardiovascular toxicity. An FDA official said this latest study, carried out over an eight year period, will require close consideration.

The UGDP study may have been prejudiced by a conflict of interests on the part of one of the inves-

tigators, a researcher in the study testified.

Angela Bowen, MD, Olympia, Wash., told the FDA "it would be on mighty thin ice" if it goes forward with its plan to require warning labels without first investigating whether the study was valid.

Describing herself as a "very reluctant witness," Dr. Bowen told the investigation took on almost a vendetta approach where Tolbutamide was involved. In addition, she said some of the deaths ascribed to that drug appeared to have been caused by factors unrelated to the diabetic conditions of the patients.

J. Richard Crout, MD, Director of the FDA's Bureau of Drugs, said he found the allegations "a little astounding" and would have to evaluate them.

Book Reviews

Diagnosis and Treatment of Thyroid Disease. By Kenneth Sterling. 113 pages. Price, \$39.95. Cleveland, Ohio: CRC Press, 1975.

The author intended this book to be "a concise, easily understood discussion of diagnosis and treatment of thyroid diseases, suitable for physicians, physiologists, biochemists, and others who may desire an introduction to this area of interest." The net result, however, is that the book seems often obscure, occasionally confusing, frequently redundant and excessively involved in the biochemical procedures used to study thyroid disease. Doctor Sterling's contributions to the advancement and deeper appreciation of thyroid physiology and pathophysiology are well known and the present criticism of his book in no way indicates a lack of considerable respect for his tremendous contributions. One should be aware that this book, despite costing nearly forty dollars, will hardly act as a ready source of general review material. Clinical aspects of thyroid disease are often covered in as few as three pages and therapies are frequently restricted to less than one page.

JOHN F. HENNESSY, M.D.

Handbook of Pediatrics, ed. 11. By Henry K. Silver, C. Henry Kempe, and Henry B. Bruyn. 705 pages. Price \$7.50. Los Altos, California. Lange Medical Publication, 1975

The 11th edition of *Handbook of Pediatrics* reaches the goal established by the authors in the preface "to present to the practicing physician and medical student a concise and readily available digest of the material necessary for the diagnosis and management of pediatric disorders." The handbook is in paperback, fits easily into a pocket and is inexpensive. Areas of controversy in diagnosis and management are avoided and therefore the text should not be relied upon as the authority on a subject.

Revisions in the previous edition are minor, the most notable being the section on the Newborn Infant.

Overall the handbook does serve as a handy source book for the emergency room and doctor's offices where basic information is needed quickly.

SARA H. SINAI, M.D.

In Memoriam

Yates W. Faison, M.D.

To have known Dr. Faison was to like him. He was an outgoing type of person, full of energy and enthusiasm and very alert to what was going on about him. He began the practice of pediatrics in Charlotte in 1913, after graduating from Harvard Medical School and interning in the Boston Floating Hospital for Children. In that year, 1913, there were 63 members in our county society.

His father, Dr. Isaac W. Faison, had practiced pediatrics here since 1892 when there were few, if any, pediatricians in the state. He was a very forceful personality, a most respected and admired doctor and greatly interested in civic and community health, having twice served on the city council.

Two years after Dr. Yates Faison located here, pediatrics was recognized as a speciality by the North Carolina Medical Society. At that time, 1915, there were pediatricians in four cities in North Carolina. In Charlotte, there were five: Dr. I. W. Faison, Dr. Yates Faison, Dr. John R. Ashe, Dr. Malcolm McLean and Dr. Myers Hunter. In 1931, the North Carolina Pediatric Society was organized and Dr. Yates Faison was president for its first three years. In that same year, there were 53 physicians listed in the directory of the American Medical Association as being interested in pediatrics in North Carolina.

Dr. Yates Faison practiced pediatrics most successfully for 27 years. This was at a time when children were treated very largely at home and when night calls were almost as numerous as day calls. Because of illness, he had to give up private practice in 1940. About the time of the Second World War, he worked at the United States Rubber Shell Plant for five years looking after the health of the employees. After the war, he was medical examiner for the Veterans Administration until he retired in 1955, having been very active in medicine 45 years.

In 1915, Dr. Faison married Miss Mary Ward Cameron, who died in 1966. They are survived by three sons, Yates W. Faison, Jr., William W. Faison and Cameron Faison and by eight grandchildren.

Dr. Faison served his city and country extremely well and we are greatly indebted to him and to his fine family.

MECKLENBURG COUNTY MEDICAL SOCIETY

Donald B. Koonce, M.D.

When I visited Donald Koonce for the last time, May 12, it was with a feeling of great distress, as I

realized his great services to his patients, his state and to organized medicine had ended. An era was over. Finality momentarily overwhelmed me. However, I quickly realized his contributions and his influence would continue. He had bridged the gap between the physicians of the '20s, '30s and '40s in this community and state, and those bright young scientists of the postwar era. He bucked the young men of the '50s initially, but readily admitted he was wrong, gaining their respect and working with them to better delivery of medical care in southeastern North Carolina. They made him the first chief of staff of the New Hanover Memorial Hospital. He led the way to make the transition from old James Walker easier.

Donald's roots in eastern North Carolina were deep. He graduated from New Hanover High School; his education continued at UNC; and his medical school was the University of Pennsylvania. Following an internship at the Protestant Episcopal Hospital in Philadelphia, and a residency in surgery at the Kingsington Hospital of the same city, he returned to Wilmington. After a year in surgery at the James Walker Hospital, he became associated with Dr. Tom Green. He rapidly built a large practice, was an outstanding physician and an accomplished surgeon. His patients loved him; his associates respected him. He was a surgeon's surgeon. He was a member of the American Board of Surgery and a founding member of the North Carolina Surgical Association, later being its president. He was also a founding member of the North Carolina Chapter of the American College of Surgeons and later its president. He was chairman of the Governor's Council on the Study of Cancer under Governor Dan Moore. He was a past president of the New Hanover County Medical Society.

Donald joined the medical society of the State of North Carolina in 1934, and served loyally and with distinction, first as counselor of the Third District for many years and later as president (1956-57). He served two terms as speaker of the House of Delegates (1959-62 and 1965-69). He was a delegate to the American Medical Association for many years and served as chairman of the North Carolina delegation at the time of his death. His honesty, keen sense of humor and statesmanship made him a respected leader in organized medicine. For the past several years, he had served as a member of the Joint Commission for Accreditation of Hospitals, representing the American Medical Association.

Donald's regard for his patients and their regard for him continued into this age of assembly line medicine.

A patient was never a number or a chart. In his final hospitalization, he was frequently found on the phone inquiring of an old patient, how he was recovering from surgery. He was a classical doctor and a master surgeon. A portion of the library in the Memorial Hospital has been set up as the Donald B. Koonce Collection of Medical Classics. We shall miss his advice, his kindness and his leadership. The hereafter is better for his being there. His memory remains with us. Thank you, Donald.

NEW HANOVER-BRUNSWICK-PENDER
COUNTY MEDICAL SOCIETY

John Ogden Lafferty, M.D.

Dr. John Ogden Lafferty died December 27, 1974, at Rowan County Memorial Hospital in Salisbury.

He was born December 10, 1917, in Charlotte, a son of the late Dr. R. H. Lafferty and Edith Fry Lafferty. He attended the Charlotte city schools, received a B.S. degree, cum laude, from Davidson College and earned his M.D. at the University of Pennsylvania.

He was a member of the Mecklenburg County Medical Society, the North Carolina Medical Society, the

American Medical Association, the American College of Radiology, the Radiological Society of North America and the Roentgen Ray Society. He was the winner of the Moore County Medal of the medical society of North Carolina for the best paper delivered at an annual meeting. He was also chairman of the commission on constitution and bylaws of the American College of Radiology and on the board of chancellors of the college.

He had been treasurer of the Mecklenburg County Medical Society. He belonged to the Charlotte Country Club and the Charlotte Rotary Club. Dr. Lafferty was a member of Myers Park Presbyterian Church and a veteran of World War II.

He is survived by his wife, Peggie Harrison; three children, John O. Lafferty, Jr., of Lincolnton, and Henry H. and Ann Lafferty of Charlotte; and a brother, Dr. Robert H. M. Lafferty of Oak Ridge, Tennessee.

MECKLENBURG COUNTY MEDICAL SOCIETY

Harold William Tracy, M.D.

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Bill, was taken prematurely from this community by a brain hemorrhage at age 46.

Bill was born October 31, 1928, in Marshall, Minnesota, the son of Harold William and Iva Tracy. He was a graduate of the University of Maryland (1950) and the University of Maryland Medical School (1954). He served his internship at the Portsmouth Naval Hospital and took part of his residency as a flight surgeon in the Navy. He completed his orthopedic residency at the Charlotte Memorial Hospital in 1961, at which time he joined the Miller Clinic.

Bill was not only my associate at the Miller Clinic but my closest friend. I will miss him a great deal. He was a mild mannered, courteous, conscientious man who took medicine seriously. His patients loved him. He was a dedicated family man and physician.

Bill gained recognition not only locally but nationally and internationally in the field of rehabilitation. He took on the care of the handicapped as a labor of love. He helped develop the Charlotte Rehabilitation Hospital into one of the most modern and efficient rehabilitation centers in the nation. He was named its medical director in 1968 and was instrumental in at-

tracting guest lecturers from throughout the United States and Europe to visit the Charlotte Rehabilitation Hospital. He established the spinal cord team approach for this community and was proud of the spinal cord unit that was being developed at the Charlotte Rehabilitation Hospital.

Just prior to his death, Bill was named "Outstanding Physician of the Year" by the Mayor's Committee on Employment of the Handicapped for his efforts on behalf of the handicapped. He was a member of the International Medical Society of Paraplegia.

Bill was a member of the Academy of Orthopedic Surgeons, Fellow of the American College of Surgeons, the Southern Medical Association, the North Carolina Orthopedic Society, an Honorary Member of the South Carolina Orthopedic Society, the American Medical Association, the North Carolina Medical Society and this society.

Our heart goes out to his loving wife, Marquerite, his son, John, and his daughters, Adrienne, Susan and Anne Marie, and the father and mother, Mr. and Mrs. Harold William Tracy.

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NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Combination Chemotherapy in Recurrent Carcinoma of the Breast, Lewis H. Stocks, M.D., Ph.D., and William W. Shingleton, M.D.; I-Thou or I-It—The Doctor and the Patient, Richard C. Stuntz, M.D., FACOG, FACS; Anton Chekhov: A Physician-Genius in Spite of Himself, Part II, Richard E. Cytowic

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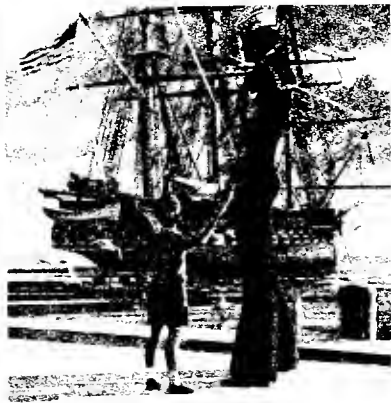
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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Combination Chemotherapy in Recurrent Carcinoma of the Breast

Lewis H. Stocks, M.D., Ph.D.*
William W. Shingleton, M.D.*

IN spite of radical surgery for carcinoma of the breast, the disease recurs in 40 to 50 percent of cases — most often within five years but sometimes as late as 20 years after mastectomy. The site of recurrence is unpredictable: chest wall, the other breast, regional nodes, liver, lungs, adrenal, and brain may be involved. Since the classic work of Huggins¹, many patients with recurrent tumor have been treated by ovariectomy², adrenalectomy³⁻⁷, hypophysectomy⁸, or by the administration of estrogens for women who are at least five years past menopause or androgens for premenopausal patients whose interval between mastectomy and recurrence is greater than two years.^{9,10} In most surgical series, effective palliation for up to 24 months has been achieved in about 35 percent of cases while improvement has been reported in approximately 20 percent of women given hormones.^{9,10} Most patients receiving nonendocrine chemotherapy for recurrent carcinoma have been given a single drug. With 5-fluorouracil, the objective re-

sponse rate was 30 percent¹¹; when cyclophosphamide, methotrexate, or vincristine are given it ranges from 10 to 30 percent.^{12,13} Griffiths¹⁴ has studied the effects of medical adrenalectomy with aminogluthethimide, a drug which has been effective in suppressing adrenal function in patients with Cushing's syndrome secondary to adenomas or carcinomas. Objective responses were obtained in three of nine subjects with carcinoma of the breast. Medical hypophysectomy (achieved by giving thyroid hormone and prednisone) effects an objective response rate of 20 percent while steroids alone provide effective short-term treatment for individuals with hypercalcemia, lymphangitic pulmonary spread, painful bony metastases, cerebral metastases and hepatic involvement associated with fever, chills and jaundice.¹⁰

Supervoltage irradiation remains an effective measure for the management of localized recurrences while intrapleural chemotherapy has been employed for the treatment of effusions¹⁶ and regional intra-arterial administration of chemotherapeutic agents has also been employed.¹⁵ In 1969, Cooper¹⁹ described the treatment of recurrent carcinoma of the breast with a combination of chemotherapeutic

agents. Of 60 unselected patients in his study, 53 had objective remissions lasting an average of ten months which appeared unrelated to age or to prior response to hormones. Remissions were observed in eight of nine instances of lung metastases, in 19 of 22 with liver involvement, in 14 of 16 with bone disease, in seven of eight with cerebral recurrence, and in five of five with skin lesions. Two deaths in the series were considered drug-related.

MATERIAL AND METHODS

Between January 1, 1971, and December 31, 1973, 41 patients with advanced recurrent carcinoma of the breast, 39 females and two males, were treated with five-drug combination chemotherapy at Duke Hospital. They ranged in age from 32 to 72 years with the mean of 52; interval between mastectomy and recurrence ranged from four months to 16 years. Sites of recurrence are shown in Table 1. Thirty of the patients had been treated previously with irradiation, hormones, or chemotherapeutic agents. Laboratory studies done before starting treatment included complete blood counts, appropriate blood chemical studies (urea nitrogen, bilirubin, alkaline phosphatase, and serum glutamic oxaloacetic transami-

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TABLE 1
Sites of Recurrences and Number of Patients Responding to Combination Chemotherapy

Site	Cases	Partial or Complete Remissions
Bone	10	7
Lung	17	14
Liver	4	2
Soft Tissue	9	7
*Brain	1	1
Totals	41	31

*This patient remained stable on chemotherapy for one year after an initial response was obtained with irradiation to the whole head

nase), urinalysis, chest x-rays, and skeletal surveys and brain or liver scans as indicated. Four drugs were employed as follows:

Drug	Dose/kg	
	body weight/ week	Maximum Weekly Dose
	mg	mg
5-fluorouracil	10.0	500
methotrexate	0.5	25
vincristine	0.02	1
cyclophosphamide	2.0	100

In addition, prednisone was given orally: 40 mg daily for two weeks, 30 mg for the next two weeks, 15 mg for the fifth and sixth weeks with gradual tapering thereafter to omission. 5-fluorouracil, methotrexate, and vincristine were given weekly intravenously through the same needle but in separate syringes; cyclophosphamide was given as a single oral dose each morning and prednisone was given in divided dose through the day. If the total white blood count fell below 3,800 or the platelet count below 100,000, all drugs except prednisone were stopped for one week.

Responses were categorized as complete remission, partial remission, or no response. A complete remission was defined as complete disappearance of any objective evidence of tumor at all observable sites. A partial remission occurred when the sum of the products of the diameters of the lesions being measured decreased by greater than 50 percent. Anything less than a 50 percent decrease in this value was considered indicative of no response. If treatment were not continued for at least four weeks, the case was excluded from the study.

RESULTS

Thirty-six of 41 patients who entered the study could be evaluated at its completion. The overall response rate in the patients completing the study was 70 percent although a complete remission occurred only once. The duration of remission varied from three to 36 months. Seventeen of the patients are alive and still being treated at this writing; nine of these have been in remission for more than a year and six for more than 24 months.

Toxic symptoms included nausea and vomiting (18 percent), alopecia (50 percent), and hemorrhagic cystitis (five percent). In two patients severe hemorrhagic cystitis developed necessitating permanent discontinuation of cyclophosphamide. The other symptoms were not considered sufficiently severe to discontinue the drug responsible. There were no drug-related deaths.

COMMENT

These studies and others demonstrate that combination chemotherapy offers effective palliation for many patients with recurrent carcinoma of the breast.¹⁷⁻²⁰ The Medical Branch of the National Cancer Institute has recently reported results in 25 patients treated by cyclic administration of a combination of drugs similar to ours: Methotrexate (60 mg/M²) and 5-fluorouracil (700 mg/M²) were given intravenously on days one and eight; prednisone (40 mg/M²) and cyclophosphamide (100 mg/M²) were given in daily oral dose from day one through day 14. No drugs were given from day 15 to day 28 when the cycle was repeated. The objective rate in these patients was 64 percent and there were seven complete remissions.²²

The most dramatic responses which we have observed occurred in patients with hepatic metastases associated with fever, chills and jaundice, some of whom were able to resume their normal activities within three to four weeks after starting treatment. Because the major side effects of therapy are nausea and anorexia, most patients who are working prefer to receive their intravenous injections on Fri-

day so that they can recover during the weekend.

The good results obtained with combination chemotherapy for a recurrent carcinoma of the breast^{12,20,21,23} do not eliminate the possibility of endocrine surgery and hormone administration in selective patients.^{9,24-26} Menopausal and premenopausal subjects who have recurrences more than two years after mastectomy and who have no evidence of hepatic or brain metastases may be strongly considered for castration together with adrenalectomy or hypophysectomy. For those more than five years postmenopausal, initial treatment should be six to eight weeks of estrogen. If such hormone therapy fails to control disease, a significant proportion of patients can be effectively treated with programs of combination chemotherapy. New patients entering our series after January 1, 1974, have been given a modified three-drug regimen utilizing oral medication entirely. The results obtained from this simpler program seemed to be as good as those reported here. The 5-fluorouracil (500 mg) and methotrexate (25 mg) were administered once weekly on the same day. The 5-fluorouracil was given in orange juice and methotrexate can be divided into two doses taken in one day. Cyclophosphamide (100 mg) is still given daily before breakfast. Prednisone is used only in subjects with metastases to brain, bone, or liver. Leukocyte counts are done every two weeks just before the weekly medication is given. Platelet counts are performed once a month. The guidelines for managing toxic reactions are unchanged. The guidelines given in this study should make it possible for the majority of patients who have recurrent carcinoma of the breast to be managed as outpatients. Referral of such individuals to medical centers for inpatient care can be limited to those presenting very difficult problems of management and to patients for whom combination chemotherapy is no longer effective.

SUMMARY

In a series of 36 patients with re-

current carcinoma of the breast who were treated at Duke Hospital, multiple-drug chemotherapy provided effective palliation in approximately 70 percent. The duration of remission varied from three to 36 months.

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"A woman's place is at home. Of course I know that there have been some women physicians who have attained eminence, and some artists, and all that. But I would rather see a daughter of mine take a more retired place. The best service to the public can be done by keeping one's own house in order and one's husband comfortable, and by attending to those social responsibilities which come in our way. The mothers of the nation have rights enough and duties enough already, and need not look farther than their own firesides, or wish for the plaudits of an ignorant public."—*A Country Doctor*, Sarah Orne Jewett, 1884, p 282.

I-Thou or I-It- The Doctor and the Patient

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THIS fragile life between birth and death can nevertheless be a fulfillment – if it is a dialogue. In our life and experience we are addressed; by thought and speech and action, by producing and by influencing we are able to answer. For the most part we do not listen to the address or we break into it with chatter. But if the word comes to us and the answer proceeds from us then human life exists, though brokenly, in the world.¹

Today as Mary approaches her doctor's office she is afraid, desperate. Yesterday at this same time she was bidding and making a grand slam. No problems — not a care in the world. Today. . . .

Last night while bathing she found a small, hard knot in her right breast. It had not been there last week. She had decided it would be foolish to worry her husband about it. Now she wished he were here to share her concern, even though he could do nothing until some questions were answered. What is it? What's wrong with me? Is it serious? What can be done for it? How will it change me? What will it cost? What are my choices? Will I be able to help make the choices? Later today, as Mary leaves her doctor's

office, she will probably still be desperate—or confused, uncertain, frustrated by not having her questions fully answered, her anxieties allayed. The reasons are various. Not only did her physician fail to answer her questions because of a felt or possibly expressed lack of time, he lacked the sensitivity to understand their implications and the intuition to answer those which remained unspoken.

Mary, on the other hand, because of the fear produced by her problem and her own way of relating to physicians, was unable to express her anxieties. Neither was able to open up to the other.

Martin Buber has written: "That people can no longer carry on authentic dialogue with one another is not only the most acute symptom of the pathology of our time, it is also that which most urgently makes a demand of us."² This appears to me to be so frequently the separating dimension between physician and patient that I believe the questions which most patients bring to their physicians and the caliber of the answers merit examination.

Mary's first question, "What is wrong with me?" is obviously a clear request for knowledge about her condition. As a physician I am required to the best of my ability to give this information accurately and

honestly and in terms the patient can understand. (Not in my pseudo-scientific or equally pseudo-intellectual, long-worded, obfuscating gobbledegook of a language!) Often, imbedded in the spoken question, however, is the unspoken concern: "Do I have a dread disease?" Mary would define dread disease as cancer. A pregnant woman might claim measles as her most dread disease. The executive with chest pain would define a heart attack as his most dread disease. The question about what is wrong hides the question as to whether this is the condition which in that particular person at that particular time is the most anxiety producing. An answer that does not cope with this anxiety is less than adequate. As Mary rehearsed her questions, the second on her list was, "Is it serious?" This question always should be interpreted by the physician as: "Will this condition cause me to die?" This is the prime degree of seriousness to most of us. Few of us have accepted our finitude in creation. Most of us live with fear in the ending of the process of life, regardless of what expectations we may have intellectually or religiously concerning life-after-death. Although much is now being written in medical, social, psychiatric and popular literature about death and

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dying, we all, physicians as well as patient, live with this anxiety. We cannot practice dying because we have no experience of our own or of others with which to program our reactions. Therefore, expressed in words or not, Mary is asking whether her condition will lead to her death, *now*. It is insufficient to her anxiety to answer, "I don't know," or "Everyone has to die," or "Let me worry about that," or, perhaps most damaging of all, "Of course not!" when you know the honest answer is simply, "Yes." For example, I am concerned by the recent comment attributed to Nelson Rockefeller who allegedly stated that he had not told his wife about the discovery of cancer in the remaining breast after her first breast surgery because "she had enough to worry about at that time." I doubt that anyone can know another well enough to decide for her that she is unable to handle anxiety producing information. I understand the motive that impels us to attempt to stand between our loved ones and their problems. However, such deception by physician or family assumes that the patient lacks the courage to face her condition. This is a large assumption to make in our world where high degrees of courage are not rare. Furthermore, it seems a gross invasion of the other person's rights to be making decisions *for* them instead of *with* them. When we resort to this, we devalue the person as a person. We stop caring for them and start taking care of them. There are always exceptions; but would you wish to be the "protected" exception?

The next of Mary's questions, "What can be done for it?" is a continuation of "What is the matter with me?" Today, unlike 50 years ago when therapies were empirical and uncertain, treatment depends on accurate diagnosis. Accuracy in diagnosis may take time and this will be accepted by most patients if the need and the reasons for the delay are clearly explained. Once the diagnosis has been made, today's medicine will provide therapy of value for most of the health problems that beset us. Cure is possible

in many, perhaps even most conditions. But if we physicians are to be consistently honest we must admit that cure, in some cases, may not be related to the therapy instituted and may occur in spite of the treatment. However, therapy of some value can be provided. And it is exactly at this point that the wisdom of the physician must be involved in the answer to the question, "What can be done for me in my affliction?" What we can do for the health problem and what should be done for the person with the health problem may not be identical. The physician must ask himself some questions at this point: What, of the various treatments available for this condition and for this patient, including the option of no treatment at all, will be better on the basis of his knowledge of the patient and of the health problem? What are the alternative treatment possibilities? How certain is he of the relative values of the recommended or alternative treatments? How much of this *certainty* is related to actual knowledge, to ignorance, or to personal treatment bias? Will the success of one or another of the treatment modalities be affected by the personal condition of the patient? By his emotional condition? By his social, educational or occupational status? The answer to the question "What can be done for my health problem?" cannot be automatic or computerized. It must be the caring response to a human in need. As Milton Mayeroff has written, "Caring itself expresses a broader meaning of humility as the overcoming of an attitude that sees others as existing simply to satisfy my own needs, and treats others as if they were merely obstacles for me to overcome, or clay for me to mold as I please. It includes overcoming the arrogance that exaggerates my own powers at the expense of the powers of others, and blinds me to the extent of my dependence, in anything I accomplish, on the cooperation of various conditions over which I have little or no control."³

What is Mary really asking, or what would we ask in similar circumstances, if the question were put, "How is this going to change

me?" She might be asking, "In what way will this health problem change my life?" or she might mean, "How will this health problem change my self-image?" Mary is asking for reassurance that the changed person she is becoming as a result of her health problem will be acceptable to herself and to others. Mary is asking the most basic questions: "After this illness, or the treatment for this condition, will the response I give or receive be changed? Will I still be the *Thou* in some other's *I-Thou* relationship? Or am I to become some *thing*, an *It* of the other's *I-It* response?" "Will the new condition affect the other's response to me, or will it affect my response to the other?" The caring answer to these questions can only come about through concern for the other as a person.

"What will it cost?" Mary asks. This speaks to all the financial problems related to health care. It is the only "cost" which can be measured and predicted accurately. In some cases, questions related to cost are an appeal for assistance and the concerned physician should be aware of financial alternatives and be willing to discuss these. I submit that there are few patients who are suggesting by these questions that they are being "gouged" or are requesting a reduction in their physician's fees. Most patients are simply asking for an honest estimate of the financial burden their health problem will present.

But Mary is not only asking for a financial estimate. She needs to know the cost in terms of time — time away from home, time away from her family and her job, time away from the life she has led up to that point. There is also the usually unspoken question of the cost in terms of pain. Very simply, Mary wants to know how much this will hurt. "How much pain will I be expected to endure?" And secondarily, "Will there be means of controlling the pain, means that will allow me to continue performing as a person?" There is, in addition, the question of the cost of the disruption of her family life. Will she need to provide support for her family during her absence, and when she

returns to what degree will she be able to resume her previous roles? With each patient there are certain to be yet other costs which require a thoughtful, considerate response.

Finally, Mary asks, "What are my alternatives?" She means, "Will I be allowed to enter into the decision making?" Questions such as these are being asked with increasing frequency, the direct result of the changing patient-physician relationship. As the physician invests his patient with increasing personhood, which at least in part means an increasing freedom to make decisions, and as the patient increasingly accepts this role, the physician must expect the patient to demonstrate her ability to respond. Equally, as the patient exhibits this increasing responsibility, she will expect the right to be an integral part of the decision-making process concerning health care. The physician must keep aware that the patient is an "other" person, this "otherness" the result of other

backgrounds, other experiences and perhaps other value systems. This "otherness" demands the respect and acceptance that all "others" must have, despite the physician's own knowledge of the patient's condition and prognosis. I may "know" that Mary's tumor may "require" radical surgery, but Mary, for a variety of reasons, may not be able to accept my recommendation. The responsibility of the patient is then to use the wisdom of her physician in making the choice of solutions to her problem which most nearly fits her needs. Frequently, but not always, these needs will be met best by the recommendations of the physician. Should the patient reject these recommendations, the physician must accept the "otherness" of his patient and confirm her right to an alternative course. This does not mean that the physician must perform a therapy or direct a course of treatment which is contrary to his judgment or to his knowledge of the

patient's condition. It does mean, however, that the physician must accept the right of this other person to be both a person and "other" than the physician is. And, in turn, this means the full, mutual acceptance of each other as persons, with full freedom to accept or reject the wisdom of both without denying the personhood of either.

Perhaps I am being unduly pessimistic in believing that Mary will be inadequately answered by her physician. It is almost certain that she will be treated in a scientifically correct manner. But in the process will the person who is Mary be lost? Or will she be supported and confirmed in a caring manner? To the Marys of the physician's professional life, how do we respond in dialogue?

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"I won't attempt to say that the study of medicine is a proper vocation for women, only that I believe more and more every year that it is the proper study for me. It certainly cannot be the proper vocation of all women to bring up children, so many of them are dead failures at it; and I don't see why all girls should be thought failures who do not marry. I don't believe that half those who do marry have any real right to it, at least until people use common sense as much in that most important decision as in lesser ones. Of course we can't expect to bring about an ideal state of society all at once; but just because we don't really believe in having the best possible conditions, we make no effort at all toward even better ones. People ought to work with the great laws of nature and not against them."—*A Country Doctor*, Sarah Orne Jewett, 1884, p 283.

Anton Chekhov: A Physician-Genius in Spite of Himself Part II

Richard E. Cytowic*

MEDICINE AND LITERATURE

ANTON CHEKHOV was admitted to the Medical Institute of the University of Moscow in 1879, despite his having misspelled "medicine" on his application. Concomitantly, he literally became head of the household in Moscow. Although one might expect that having been abandoned to himself he might likewise relinquish his family, Chekhov found it hard to turn his back on his relatives. His father Pavel had become totally ineffective, and the obligation of support and decision making fell to Anton, or "Father Antosha," as the family called him. To this end he began writing for the comic weeklies; not only short stories, but jokes, captions for cartoons, advertisements, recipes, aphorisms — anything that would bring in money. "Oh, with what trash I started" he later said. "Oh my God, with what trash!"

His first story, "Letter From a Don Landowner to His Scholarly Neighbor," was published in *Grasshopper* in March, 1880, signed with the pseudonym "V . . .". He spent his first honorarium on a large cake for his mother's birthday and arranged a proper party. More work followed at top speed, his first drafts

being "printable" and others, such as "The Siren," being written without a single erasure. He published nine stories in 1880 and 129 stories, articles and reports by 1885, using such pen names as "The Man Without Spleen," "My Brother's Brother," "Hot Iron" and, mainly, "Antosha Chekontey." The zeal with which he wrote was clearly backed up by need, and despite a rather handsome income there never seemed to be enough money. "I place great importance on money," he wrote. "I was born, grew up, was schooled, and began writing in an environment in which money played a shockingly large part" (August 29, 1888). In an unusual selfish vein, he wrote that if he lived alone, he should live like a rich man. He worked, nonetheless, to support a household like one might find in a Chekhov play — an indolent father, a sick mother, an alcoholic brother and other siblings, and miscellaneous permanent "guests" all depending on the young doctor-writer for support:

I write in the most hideous circumstances. Before me is my medical work mercilessly whipping my conscience; in the next room howls the child of a relation who has come to stay with us; in the other room my father is reading aloud to my mother "The Flaming Angel" . . . someone has wound up the music box and I can hear "Fair Helene." I long to run away to the country, but it is one

o'clock in the morning. It is hard to imagine a setting more abominable. . . .

Home life was not his only source of complaint, for medicine provided its own unique professional disadvantages:

My bed is occupied by a visitor who comes to me every now and then and starts a talk on medicine. I have the misfortune of being a medico, and there is no one who doesn't consider it necessary to chat with me on medicine, or, when bored by medicine, broaches the subject of literature (both August 24, 1883).

At times he was disillusioned with medical school and sighed a complaint frequently heard today: "We repeat by rote, like school-children, only to forget everything afterwards as fast as we can." Still, he applied himself to study and during his fourth year proposed work on a scientific monograph which at that time would have sent the censors into apoplexy: *A History of Sexuality*. He decided, however, to try a less risqué subject and wrote his thesis instead on *The History of Medicine in Russia*.

He had by this time ingratiated himself into the Moscow intelligentsia, which, after Chekhov had attained his M.D. degree in 1884, naturally consulted him gratis. Money continued to come in from his writings, now expanded to the widely read humorous weekly,

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Splinters. An 86-page collection of stories, *Tales of Melpomene*, appeared that summer. Compared to his royalties, however, the fees from his first medical work seemed a windfall: Five rubles for a young lady's toothache (which he didn't even cure), a single ruble from a monk with dysentery and three rubles from a vacationing actress with a nonspecific stomach ailment. These earnings were quickly spent at the local *traktir* to buy his friends "vodka, beer, and other medicine."

Unselfishness, friendship, gentility and a detestation for all forms of deceit and coercion — these were most remarkable traits for a man who lived a youth of fear, insecurity and uncertainty. It is interesting to speculate that Chekhov's personal "work ethic" was an outgrowth of the perverted religious model forced upon him earlier and the sense of guilt instilled with it. It was impossible to say no to a requested favor, to charge peasants for medical care or ignore a call for help during the night. He was a major benefactor of the Taganrog Municipal Library and sent it cases of books that he gathered during his extensive European travels. He fought diligently and raised money to save the failing medical journal *Surgery*, organized the care of cholera and typhus victims during epidemics and supervised both the financing and construction of several schools in Yalta and other provinces.

I have no partiality for police, or butchers, or scholars, or writers, or young people. I regard trademarks and labels as prejudicial. My holy of holies is the human body, health, intelligence, talent, inspiration, love, and absolute freedom — freedom from force and falsehood, no matter how the latter manifest themselves (October 4, 1888).

Chekhov suffered from an enormity of conscience and a paucity of self-esteem. Like so many of his characters he brooded over his "insignificance" and questioned the very purpose of his life. "I have no faith in myself as a doctor," he confessed to Alexander in 1885. He was at that time assigned as the district *Zemstvo* physician in Zvenigorod, about 30 miles outside Moscow, where he saw 30 to 40 patients half of the day and spent the rest "dreadfully bored, seated at the window and gazing at the dark sky." During

the summer he saw almost 1,000 peasants from whom he collected a total sum of one ruble. Clearly, he was not in medicine for the money. Perhaps his frenetic schedule was a means of denying his own worsening pulmonary illness.

The year 1886 provided him with cause to feel worthwhile as fame of the unseen "Chekontey" continued to spread throughout Russia. Upon visiting the artistic and publishing capital of Petersburg, which he had never seen, Chekhov was welcomed "like the Shah of Persia." Then came the letter from the eminent novelist D. V. Grigorovich affirming that he had "talent which puts you in the very highest rank of the new generation of writers" (March 1886). Soon thereafter, Chekhov began writing for the prestigious daily, *Novoye Vremya* (*New Times*), and became close friends with its influential publisher, Alexis Suvorin. His writing now became less prolific and more substantial. In October of 1888, the Department of Russian Language and Literature of the Petersburg Academy of Sciences awarded him the illustrious Pushkin Prize for his collection of stories, *In The Twilight*. Even this tremendous success at 28 was not enough to convince Chekhov of his worth. "As it is," he lamented, "I am a Lilliputian like everybody else." He discredited all his writings as "insignificant," "excrement" and "trivialities," and continued to be torn between an identity as a writer or as a physician. This constant sense of insignificance and unfulfillment was to haunt Chekhov to his grave. He realized that he sought the explanation for his internal uncertainty through external sources; his characters also use this defense mechanism frequently by blaming the world, their predicament or each other for their wasted lives, unrequited loves and even the changing times.

In reply to Grigorovich's letter, Chekhov wrote:

I felt that I did have talent, but I was used to thinking it insignificant. Purely external causes are enough to make one unjust to oneself, suspicious, and diffident. There have been plenty of causes in my case. . . . In the five years I have been knocking about newspaper offices I have come to accept this gen-

eral view of my literary insignificance. That's the first cause. The second is that I am a physician and am up to my ears in medical work, so that the saying about chasing two hares has robbed no one of more sleep than me. [Reference to a Russian proverb, *Za dvumya zaytsami pogonishsya, ni ognovo nye poymayesh*: Chase two hares and you catch neither] (March 28, 1886).

He was becoming increasingly disgusted with life:

I am finding life tedious and, at times, I begin to hate it — something that never happened to me before. Lengthy, stupid conversations, guests, people asking for favors, having to pay cabbies for patients who don't have a cent — one might as well run out of the house. People borrow money from me and don't pay it back, walk off with my books, don't consider time of any value. The only thing lacking is an unrequited love (December 23, 1888).

The Island of Sakhalin

It was at this time, in a symbolic way of "running out of the house," that Chekhov embarked on his famous journey to the penal colonies on the island of Sakhalin. Many have wondered what provoked this physician, aware how ill he was, to undertake so quixotic and strenuous a journey. At least he had ample time for personal reflection:

Travel absolutely must be solo. To be with one's thoughts sitting alone in a carriage or a room is considerably more interesting than being with others' (June 13, 1890).

He ostensibly proposed to singlehandedly make the 3,000-mile trip to compile a census and epidemiological treatise on the life of the exiled prisoners "and thereby pay off some of my debt to medicine," he told Suvorin, "toward which, as you know, I have behaved as a pig." The long journey undoubtedly fulfilled unexplicable needs, because no amount of reason could dissuade Chekhov from going. Was Sakhalin an "external source" to which he referred in his letter to Grigorovich? Was it his debt to society, the gesture that would finally make him feel that he had finally contributed something worthwhile to the betterment of the human race?

When man does not understand, he senses discord within himself; he seeks the reason for this discord not in his own self, as he should, but outside himself, whence comes the war against what he does not understand (May 15, 1889).

Caught by "mania Sakhalinosa," Chekhov prepared for the trip by reading everything he could find

about Sakhalin. Many of his friends, especially his devoted sister Masha, helped research the Siberian penal colony. The government, however, was quite resistant in offering official help or disclosing information since Sakhalin also housed political dissenters. Since the trans-Siberian railroad had not yet been built, the journey was on horse, on foot, by boat and in *Kibitka*, "an old bone-shaking basket attached to two horses." It is not surprising that this strenuous three month trip instigated many bouts of coughing and bloody sputum. His investigation was painstakingly thorough, and after four months of interviewing every convict and settler on the island, he had collected nearly ten thousand index cards, each with notes in 13 categories.

The trip was financed by Chekhov's writings. He sent en route travel sketches, accounts of Siberian life and reports of penal conditions to Suvorin, who serialized them in *New Times*. In 1892, *The Island of Sakhalin* appeared as a book but was greeted with little notice from either the critics or the general public. Instead of being a tense, dramatic account of prison life as is Dostoevsky's *From The House of The Dead*, it is a boring, statistical manuscript that tells the truth with no literary subjectivity. But it does contain vivid accounts of a brutal flogging, the rampant prostitution among the young girls (some only 12) and interesting cases of indigenous diseases, some from infection, but most from poor sanitation. The book was even rejected as a thesis by the dean of the Medi-

cal Institute of Moscow University, who merely peered at Chekhov over his spectacles, turned around and walked out of the room without a word. The Doctor of Medical Sciences degree would have qualified him as a *privatdozent*, allowing him to lecture in the medical school.

There is disagreement among his biographers whether Chekhov's disclosure of the facts brought about any change on that Devil's Island or in penal reform in general. The empirical result, however, seems to be that Sakhalin was an insignificant gesture by a man who himself felt insignificant. For those interested in 19th Century medicine, it does provide some interesting accounts of medical practice in the remote and sparsely populated areas of Russia and Siberia. For example, while passing through the provincial district of Tomsk, he writes:

There is diphtheria. Smallpox is everywhere, but oddly enough it is not as infectious as it is elsewhere. There are no hospitals or doctors. The sick are treated by male nurses. Bloodletting and cupping are practiced here on a grandiose, brutal scale. On the road I examined a Jew with carcinoma of the liver. He was emaciated and scarcely breathing, but this did not prevent the nurse from placing twelve cupping glasses on him (May 16, 1890).

Chekhov was an inveterate observer of human behavior and custom, so it is not surprising to read entries on the local life. How strange it was, he wrote, to see the peasant girls and women smoking cigarettes. "Ah, what liberalism!" There was a similar liberalism in the conversation in the Cossack villages. Since there was no censor to worry about, the air "frequently

became red-hot from the talk." Chekhov became red hot himself when treated to a tour of the local brothels by a Cossack police chief at 2 a.m. "Disgusting!" In Listvenichnaya, on the shore of Lake Baikal, he made the epidemiological observation that the population practically subsisted on wild garlic. Ready money could not conjure up fish, meat or milk. "But then there is vodka!" noted Chekhov, concluding that drinking vodka must be considerably more interesting than catching fish or raising cattle in Baikal. His experience also extended to veterinary medicine, and he and a Dr. Shcherbah passed sentence on the sick cattle on board the ship taking Chekhov to Singapore. The doomed were slaughtered and thrown overboard.

At this time, cholera was rampant — in Vladivostok, Japan, Shanghai, Suez, and moving down the Tartar Strait to South Sakhalin. Chekhov and the felons were fortunately spared this disease. In fact, he was spared distress from his own illnesses, it seems, and he wrote to Masha in June of 1890 that "I am in perfect health." Certainly his stalwart Muscovite constitution did not stop him from bathing in the frigid waters of the Amur river in Vladivostok. Even when suffering from scotomata, migraine, hemorrhoids and his chronic gastrointestinal ailment ("intestinal catarrh") he was able to muster enough strength to drink champagne with the Japanese Consul of South Sakhalin.

(to be continued)

The wielder of ideas has always a certain advantage over the dependor upon facts; and though the two classes of minds by no means inevitably belong, the one to women, and the other to men, still women have not yet begun to use the best resources of their natures, having been later developed, and in many countries but recently freed from restraining and hindering influences.

Editorial

HEARTS AND FLOWERS

The JOURNAL will have something to say in 1976, our bicentennial year, about changes in man and medicine in 200 years if the editorial staff can confer sufficient order on a chaos of data. In preparation for that exercise, it is appropriate to mark 1975 as a bicentennial year also, not for the United States alone but also for both patient and physician in any quarter of the globe. For in 1775, William Withering commenced his clinical studies of the effect of the foxglove, *digitalis purpurea*, the active constituent of a dropsy remedy used by a woman in the country, the results of which he would publish ten years later. Withering had gone north from England to medical school in Edinburgh, the center of medical learning at the time, where he also learned to play golf, one of the first physicians to seek solace at the pin and cup. Along the way he acquired some knowledge of geology and in 1784 first identified crystalline barium carbonate, now called witherite, the only one of his achievements deemed worthy of recognition by the editors of the 1956 version of the *Encyclopaedia Britannica*.

If Withering had selected milkweed of the family *Asclepiadaceae* or monarch butterflies (*Danaus plexipus*) as his sources of cardiac glycosides, his results might have been similar and he might have identified milkweed poisoning in blue jays before *digitalis* intoxication would be recognized in man. During their larval stage, monarchs extract cardenolides from their food plants, *Asclepias curassavica* and others, and store them in different forms and in varying concentrations in wings, abdomen and thorax; concentrations are higher in females who are smaller than males suggesting that storage occurs at some biological cost. Around 22 glycosides have been isolated in *A. curassavica*, ten of which have been identified in adult monarchs. Highest total concentrations are found in wings but compounds of greatest emetic potency are preferentially retained in the abdomen.

What is the value of such differentiation in concentration and biologic activity? According to Brower

and Glazier,¹ some birds are acutely sensitive to bitter tastes so that a little bit of a compound may go a long way. Thus, if bitterer compounds are sequestered in the wings of some butterflies, predators, blue jays for instance, with exquisite gustatory appreciation would learn to avoid such species. If hungry birds are not deterred and eat the rest of the butterfly anyway, they encounter the more emetic cardenolides, throw up and even die of intoxication. Beak marks can be recognized in the wings of these butterflies suggesting that many birds indeed have a well-established diversion to monarchs.

If an advocate of natural foods elects to pursue the milkweed to the monarch at the table, with the false hope of escaping the bitter taste of the plant, he would be disappointed. For if he ate two dried male butterflies, he would be dosing himself with a total digitoxin equivalent of 1.25 mg, adequate for digitalization. If he preferred the female, his intake would be an equivalent dose of 1.76 mg which would probably be toxic. Perhaps botanists who named milkweed *Asclepias* (*Aesculapias*, father of medicine) labelled better than they knew. At any rate, butterfly weed, one of the gorgeous ornaments of midsummer, and so-called because of its gay color, is of the milkweed family (*Asclepias tuberosa*), may harbor danaid larvae and is also known as pleurisy root because its deep root was once considered a sovereign remedy for pleurisy.

At milepost 415.7 (696 km) at the Cherry Cove parking overlook on the Blue Ridge Parkway, elevation 4,330 feet (1,500 meters), stands an easel display which marks the route of migration of the monarchs. Those of us who have followed their migrations either on the Parkway or in the Piedmont have only been impressed by the intensity and persistence of the migratory danaiids. The hardiest survive, the females despite being smaller and possibly because they contain more glycoside, a good trade.

References

1. Brower LP, Glazier SC: Localization of heart poisons in the monarch butterfly. *Science* 188:19-25, 1975.

Correspondence

AMA HOUSE OF DELEGATES

June 15-19, 1975

To the Editor:

In June, at the most momentous and longest session in recent years, the House of the American Medical Association called for continued efforts to rebuild the AMA on a sound financial basis, to maintain essential councils and committees, to reshape the publications program and to maintain the scientific program.

The House repeatedly emphasized stronger AMA involvement in confronting problems faced by local physicians.

The delegates unanimously endorsed the recent suit filed by the AMA as a result of which an injunction was obtained in federal court restraining HEW from implementing post-admission certification. This order was reaffirmed by the court on June 30 and HEW appealed July 10 to the 7th Circuit Court of Appeals. It may take six months before a decision is handed down. Meanwhile, the injunction remains in full force.

The board was encouraged to continue to take such action on further legislation or regulations which threaten the ability of physicians to provide quality medical care.

The delegates instructed the board and the Council on Legislation to develop draft legislation rectifying abuses in the promulgation of regulations in the Federal Register.

Regarding publications, the board was told to maintain JAMA as the No. 1 medical publication in the country and to keep it and AM NEWS part of dues benefits. The delegates authorized subscription charges for specialty journals and Today's Health and the phasing out of PRISM, which may take six months or more in order to avoid financial loss.

An overwhelming majority of the House approved a dues increase to \$250 per year in order to finance these objectives. This is an increase of \$80 over the current \$110, plus \$60 assessment. Beginning 1976, dues will amount to about \$21 per month. About 600 North Carolina physicians have not paid the \$60 AMA assessment. This is needed very much since failure to achieve full payment may jeopardize our quota of delegates. Any of you who have overlooked this are respectfully urged to send your \$60 directly to the AMA. Suing the Feds may be the best way to go with some of our problems; it is expensive.

Reorganization of the AMA at the top level was

proposed by incoming President Max Parrott. His proposal would eliminate the offices of president-elect, president and immediate past president. The chairman of the trustees would be elected by the House and would be the official spokesman for the organization. The executive vice-president, a full time salaried position, would speak for the staff, which has been trimmed to the bone. Finally, the House is convinced that we now have an extremely conscientious and capable board, responsive to the needs of the membership and their patients, and responsible for strengthening the AMA and maintaining it as an effective, vigorous organization. The AMA is the only ship big enough to hold all clinical specialties, educators, researchers, interns and residents. It is the one place where we physicians can make a unified national effort in support of undergraduate and graduate medical education; of good medical legislation; of combatting quackery; of resisting governmental interference in medical matters; of keeping the voices of physicians heard in the areas of hospital management, education standards, residency training and specialty certification.

North Carolina now has four delegates in the AMA House. If we can obtain full payment of the assessment and add 300 more AMA members in this state, we may be eligible for one more delegate. Your continued support is very much appreciated.

DAVID G. WELTON, M.D.

3535 Randolph Road, 101-W

Charlotte, North Carolina 28211

INSECT STING EMERGENCY FIRST AID KIT

To the Editor:

Recently I have been concerned in what seems to be a one-man crusade about the inadequate knowledge of the use of the insect sting emergency first aid kit and its being available to those who should have it on hand in case of a severe insect sting reaction. For example, the following groups of people usually do not have the kit or the knowledge of its use and yet they are more likely to be faced with this situation: School nurses or principals, forest rangers, scoutmasters, golf pros, swimming instructors and tennis pros. I feel that some deaths could have been prevented by making this kit available to these people, with instructions for its use.

Section 90-18 of the North Carolina Medical Practice Act states that it is against the law for these people

to give injections and yet we physicians give insect sting kits to our insect allergy patients and train them in their use. I think that the law should be changed. These people should be trained in the use of the emergency insect sting kit and allowed to give epinephrine in cases of a life or death situation. I hope others feel the same as I and will help to get the laws changed so that this can be done. I would wish that all persons feeling as I do would write to their state legislators to get this law changed.

I know of two instances where the use of this kit could have prevented death in the individual who suffered the severe reaction. I would appreciate hearing from others who know of similar cases in which the use of an insect sting kit would have prevented the death of a person.

CLAUDE A. FRAZIER, M.D.
Doctor's Park
Asheville, N.C. 28801

SURGICAL MANAGEMENT OF MORBID OBESITY: A CLINICAL TRIAL

To the Editor:

Jejuno-ileal bypass is performed with increasing frequency for the treatment of morbid obesity. Gastric bypass, less well known, has been performed in more than 400 patients at the University of Iowa Hospitals. The operative mortality of both operations is two to three percent. The most common immediate post-operative complication is wound infection. The late complications which have been reported include persistent diarrhea with protein and electrolyte deficiencies, progressive fatty infiltration of the liver with liver failure with a rare death, an increased incidence of urinary tract stones and a too large or too small gastrojejunostomy. The amount of weight lost following the two operations is reported to be similar. A prospective, randomized study is needed to determine which is the better operation. Weight loss and morbidity are the two important criteria which would determine which is the better. Such a study is now in progress at North Carolina Memorial Hospital. The criteria used to select patients, who must be between ages 20 and 50, are: (1) More than twice normal weight for five years or more; (2) failure to lose weight on an adequately medical-supervised dietary program; (3) no endocrinopathy to explain the obesity; (4) no peripheral vascular manifestations of diabetes mellitus and (5) no contraindicating psychiatric problems.

When accepted, the patient is admitted to the Clinical Research Unit. There is no charge to the patient for hospitalization, laboratory or surgery. An appointment for a patient to be evaluated for the morbid obesity project can be made by writing to Dr. J. A. Buckwalter, Department of Surgery, University of North Carolina, Chapel Hill, North Carolina, or by calling 919-966-4416.

JOSEPH A. BUCKWALTER, M.D.
Department of Surgery
University of North Carolina
Chapel Hill, North Carolina 27514

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Emergency Medical Services



INFORMING THE PUBLIC REGARDING CARDIOPULMONARY RESUSCITATION (CPR)

John W. Sturgeon, Assistant Director
American Medical Association
Department of Emergency Medical Services

Sudden death from heart attack is the most prevalent medical emergency today. More than 650,000 die annually and 350,000 of these deaths could be prevented by prompt, appropriate treatment, including Cardiopulmonary Resuscitation (CPR).

CPR is the hope for a longer life for the heart attack victim. All medical professionals have a responsibility to inform the general public about the importance of CPR and to instruct as many of the general public as possible in the techniques of CPR.

CPR can be learned by any person with or without formal education. The only real requirement is physical capability and the willingness to devote four (4) hours to learning CPR techniques.

One approach to the problem of recruitment is through the country's educational system. Capable instructors can be recruited and taught prior to institu-

tion of the school programs. The instructors' course can be given during the summer months with the school system giving additional credits for teachers attending the CPR instructors' course.

A total of twenty-one hours is involved in the instructors' program. Organizations such as the local medical society, the American Heart Association, American Red Cross, or the Public Safety Officers Foundation can be called upon for assistance in obtaining a qualified CPR instructor. Once the school system has qualified instructors, CPR classes can be made available to all students during a regularly scheduled health class.

The inspiration for promulgation of such a vitally important program must come from you, the reader of this article.

—Abstracted by JACK B. PEACOCK, M.D.

From "Emergency Medicine Today," Vol. 4, No. 7, July, 1975, John M. Howard, M.D., Editor. Original article may be obtained from the Commission on Emergency Medical Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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WHAT? WHEN? WHERE? In Continuing Education

November 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For Information."

PROGRAMS IN NORTH CAROLINA

November 20-22

North Carolina Academy of Family Physicians 27th Annual Scientific Assembly

Place: Hyatt House, Winston-Salem
 For Information: Faye Whitfield, Executive Secretary, 1002 Wake Forest Road, Raleigh 27604

November 21

Duke Medical Alumni Symposium
 Place: Duke Hospital Amphitheater
 Program: Genetics-Environment-Management: Diabetes and Hypertension
 For Information: Office of Continuing Medical Education, Duke University Medical Center, Durham 27710

November 21-22

Second Annual Arthritis Symposium
 Fee: \$35
 Credit: 9 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 4-5

North Carolina Regional Meeting of the American College of Physicians
 Place: Winston-Salem
 For Information: John T. Sessions, Jr., M.D., F.A.C.P., UNC School of Medicine, Chapel Hill 27514

December 5-6

Family Practice Workshops
 Program: Participants will choose six of 18 topics
 Fee: 6 topics at \$15 each
 Credit: 12 hours; AAFP credit applied for
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

December 13

Annual Staff Meeting, Department of Ophthalmology, North Carolina Memorial Hospital and McPherson Hospital
 Place: UNC School of Medicine Clinic Auditorium
 Sponsors: UNC School of Medicine, Department of Ophthalmology, and McPherson Hospital
 Credit: 8 hours
 For Information: Samuel McPherson, Jr., M.D., Department of Ophthalmology, UNC School of Medicine, Chapel Hill 27514

December 13

Epilepsy Workshop
 Place: 103 Berryhill Hall
 Fee: \$10
 Credit: 7 hours; AAFP credit applied for
 For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

December 13

Geriatric Medicine for the Practitioner
 Place: Duke Hospital Amphitheatre
 Sponsors: Duke University Center for the Study of Aging and Human Development; American Geriatrics Society; Duke Family Practice Clinic
 Fee: \$35; registration limited
 Credit: 6 hours; AAFP credit applied for
 For Information: Dorothy Heyman, Executive Secretary, Center for the Study of Aging and Human Development, Box 3003, Duke University Medical Center, Durham 27710

January 15-17

Epilepsy for Pediatricians
 Sponsor: American Academy of Pediatrics
 Fee: members \$100; non-members \$135
 For Information: John F. Griffith, M.D., Box 2975, Duke University Medical Center, Durham 27710

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient
Fee: \$135
Credit: 15 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 30-31

Conference for Medical Leadership
Place: Royal Villa Hotel, Raleigh
For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

February 7-8

Endoscopy Workshop
Place: Berryhill Hall
Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine
Fee: \$75
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

February 11

Wingate M. Johnson Memorial Lecture
Place and time: Babcock Auditorium, 11:00 A.M.
Speaker: Dr. Grant Liddle, Professor and Chairman, Department of Medicine, Vanderbilt University School of Medicine
Credit: 2 hours
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 21-22

Clinical Application of Biochemical Determination in Drug Treatment of Affective Disorders
For Information: Joseph Parker, M.D., Department of Psychiatry, Box 3837, Duke University Medical Center, Durham 27710

February 23-27

The Management of Craniofacial Pain
Sponsors: UNC School of Dentistry, School of Medicine, Dental Research Center and School of Nursing. Presented by UNC Pain Clinic
Fee: \$200; enrollment limited to 80 participants
Credit: 29 hours; AAFP credit applied for
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 5-6

Refresher Course in General Radiology
Fee: \$100
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 19-20

E. C. Hamblen Symposium in Reproductive Biology and Family Planning
For Information: Charles B. Hammond, M.D., Box 3143, Duke University Medical Center, Durham 27710

March 22-26

Radiology of the Urinary Tract—a Tutorial Postgraduate Course
Program: Emphasis on personalized small group tutorial type teaching. Subject matter will cover all facets of urinary tract disease, including comprehensive coverage of diagnostic techniques
Fee: \$300
Credit: 30 hours
For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 25-26

Medical Alumni Day and Scientific Meetings
Place: Berryhill Hall
Sponsor: Office of Continuing Education and Alumni Affairs
Credit: To be announced
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 26

Symposium on Alcoholism
Fee: \$25
Credit: 6 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 29-30

Obstetrics and Gynecology Postgraduate Course
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 9-10

Practical Pediatrics
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 9-10

Annual Arthritis Symposium
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 16-17

Practical Nuclear Medicine: Emphasis Oncology
Fee: \$75
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 23-24

Perinatology Post-Graduate Course
For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 23-30

Medical Symposium—Cruise to Bermuda
Sponsors: Bowman Gray School of Medicine and the Medical University of South Carolina
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 30-May 1 (note change in date)

Diving Deafness and Related Physiology
Fee: \$35
Credit: 9 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 12-13

Breath of Spring '76: Respiratory Care Symposium
Fee: \$25
Credit: 12 hours; AAFP credit applied for
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

ITEMS OF SPECIAL INTEREST

The 1975 *Revised North Carolina Dietetic Association's Diet Manual* as well as revised diet pages for those who already have the manual are now available. The cost of the manual is \$10.40; the packet of revised pages is \$2.60.
For Information or to order: Karen C. Hauerperger, NCDA Executive Secretary, 5836 Gate Post Road, Charlotte 28211

November 16-19

1975 Annual Scientific Meeting of the Southern Medical Association
Place: Houston Oaks, Houston, Texas
Program: Post-graduate courses offered as part of the meeting will include: Basic Fetal Monitoring; Children's Orthopaedics; Gastroenterology; EKG Morphology of Peripheral Blood Smears

and Bone Marrow Sections; Diagnosis and Treatment of Platelet Disorders; Prevention and Control of Hospital-Associated Infections; Respiratory Therapy; Hypospadias, Epispadias, Peyronie's Disease, and Other Conditions Causing Penile Curvatures; Advanced Fetal Monitoring; New Developments of Detection, Treatment, and Follow-Up of Gynecologic Malignancies; Office Management of the Infertile Couple; Hand Surgery (Part I and Part II); Pediatric Urology; Pediatric Dermatology; Dermatology for Non-Dermatologists; Functional Cast Bracing; and Disorders of Fluid, Electrolyte, and Acid-Base Balance.

Credit: All courses are approved for hour-for-hour AMA Category I credit

For Information: Southern Medical Association, 2601 Highland Avenue South, Birmingham, Alabama 35205

University of Maryland CME

The Program of Continuing Education of the University of Maryland School of Medicine has a broad range of two and three day CME courses available to interested physicians. The schedule through the 1975-1976 academic year includes such topics as neuropathology, dermatology, gastroenterology, blood diseases, pulmonary conditions, psychiatry for the family physician, internal medicine, sexual abuse, obstetrics, child development, drug abuse and a family practice review course.

For Information: Steven L. Barber, Educational Coordinator, Program of Continuing Education, University of Maryland School of Medicine, 29 South Greene Street, Baltimore, Maryland 21201

PROGRAMS IN CONTIGUOUS STATES

December 7-10

Structure-Function Correlations in Cardiovascular Disease
Place: The Williamsburg Conference Center, Williamsburg Lodge, Williamsburg, Virginia

Fee: ACC members \$125; non-members \$175

Credit: 20 hours; AMA Category I

For Information: Miss Mary Anne McNerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

January 31

Workshop on Infectious Diseases and Antimicrobial Therapy
For Information: Doris Croley, Education Director, Oak Ridge Hospital of the United Methodist Church, Oak Ridge, Tennessee 37830

May 10-13

The Frontiers in Cardiology

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine in cooperation with the Georgia Heart Association

Fee: ACC members \$125; non-members \$175

Credit: AMA Category I

For Information: Miss Mary Anne McNerny, Director, Department of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P. O. Box 8248, Durham, N. C. 27704, by the 10th of the month prior to the month in which they are to appear.

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AMA-ERF WHAT AND WHY?

Unfortunately there are too many auxiliary members—and too many doctors—who do not know what AMA-ERF stands for. AMA-ERF (American Medical Association—Education and Research Foundation) has a twofold purpose: (1) to raise funds for medical education, in the giving of unrestricted funds to medical schools and (2) to provide loans for medical students, interns and residents. AMA-ERF is one of the greatest ways the auxiliary can be of service to the medical profession. By our efforts throughout the year we can contribute interest, time and the money for assistance in medical education. What better investment can we make? Every dollar contributed to AMA-ERF goes for the designated purpose. Medical schools received \$1,016,392.74 in March, 1975, in unrestricted AMA-ERF funds representing contributions received during 1974. North Carolina gave \$23,950.71, an increase over each previous year. Our aim for this year is to reach every doctor's wife (or husband) and ask each to give at least \$15 to AMA-ERF. We must also encourage every doctor to give to his medical school—hopefully—through AMA-ERF. We are continuing our established projects through the auxiliary, including the Christmas "Sharing Card." This has been successful in raising a sizeable amount of money and it is helpful for busy doctors' families. We will again sell quality Christmas cards to individuals with 40 percent of sales going to AMA-ERF. County chapters are urged to be thoughtful and innovative in finding projects to suit their particular areas. We also will continue to have quality items to sell through the auxiliary. The watches are still selling well and are more attractive than ever. We are also stressing direct contributions, using the attractive cards provided by the AMA-ERF office as a means of thanking a physician for services and kindness, honoring a physician-colleague or giving as a memorial in the event of death of a doctor, a doctor's friend or a member of a doctor's family. Thank you for your support of AMA-ERF.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Dr. Cecil G. Sheps, vice chancellor for health sciences at UNC-Chapel Hill has been named a member of the newly established Health Policy Committee of the Association of State Universities and Land Grant Colleges.

The Association has sought the counsel of many of

the nation's most distinguished health leaders for this committee in order to be advised on health matters broader than those covered by traditional medical schools.

* * *

Dr. Priscilla B. Wyrick of the UNC School of Medicine has received a grant to study the bacteria responsible for the leading cause of blindness in the world.

Funded by the National Council to Combat Blindness, Inc., the one-year study will examine the intracellular activity of the bacteria Chlamydia. Dr. Wyrick, assistant professor of bacteriology and immunology, will look for the release of components that produce disease.

* * *

Dr. John K. Spitznagel of the UNC School of Medicine at Chapel Hill has received funds to support a predoctoral fellow from the biological sciences component of Lilly Research Laboratories.

The fellowship, which will support a graduate student studying under Dr. Spitznagel, is one of four awarded nationally to professors who have demonstrated outstanding research and teaching abilities. Dr. Spitznagel is a professor of bacteriology and immunology.

Edward Calamai, a third year student in Dr. Spitznagel's laboratory, has been chosen to receive the fellowship which will pay him a stipend for two years. The award also will pay his tuition and allow money for research needs.

* * *

Dr. Arthur J. Prange, Jr., professor of psychiatry at the UNC School of Medicine at Chapel Hill, has been elected chairman of the Clinical Projects Research Review Committee of the National Institute of Mental Health (NIMH).

* * *

Dr. Thomas W. Farmer has been named Sarah Graham Kenan Professor of Medicine at UNC-Chapel Hill.

A native of Lancaster, Pa., Dr. Farmer came to Chapel Hill in 1952, when the medical school became a four-year, degree-granting institution. Since that time he has been professor of neurologic medicine and chief of the division of neurology.

He is a graduate of Harvard and Harvard Medical School, where he was elected to Alpha Omega Alpha medical honorary. He received the M.A. degree from Duke University and also attended Franklin and Marshall College.

* * *

Dr. John C. Cassell of the UNC-Chapel Hill School of Medicine has been elected to the Institute of Medicine of the National Academy of Sciences.

Dr. Cassell, professor of epidemiology in the School

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of Public Health, joins three other UNC professors in the 306-member organization.

Institute members are elected by the existing membership on the basis of demonstrated achievement and interest in problems and issues involving health care, disease prevention, medical education and medical research.

Dr. Cassell, former chairman of the department of epidemiology, specializes in the study of coronary heart diseases and has done much research and active work in the areas of heart and lung disease. He received his B.Sc. and M.B.B. Ch. at the University of Witwatersrand, South Africa, and his M.P.H. from UNC.

* * *

Dr. Barbara S. Hulka of the UNC School of Public Health has received the third annual Award for Excellence presented by the Statistics and Epidemiology Section of the N. C. Public Health Association.

Dr. Hulka was cited for her contribution in the area of cervical cancer epidemiology. Since 1967 she has been the principal investigator of an innovative, large-scale research project studying primary health care. The project is unique since it represents a joint effort between the American Academy of Family Practice and the UNC department of epidemiology.

Dr. Hulka is a professor in both the UNC School of Medicine's department of family medicine and the School of Public Health's department of epidemiology.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Duke Hospital, which treats nearly 40,000 emergency cases a year, has brought in a specialist in trauma (injury) who will direct an expanded, comprehensive emergency treatment program.

He is Dr. Joseph A. Moylan, Jr., who was director of the Emergency Medical Service Program at the University of Wisconsin Center for Health Sciences before his appointment here this month.

Moylan also was co-director of the Center for Trauma and Life Support there and was chief of the University of Wisconsin Burn Unit.

His appointment was announced by Dr. David C. Sabiston, chairman of the Department of Surgery.

"Over the past several years," Sabiston said, "the field of surgical trauma has evolved as a definite entity. Specialists in trauma have begun to appear, and Dr. Moylan is a nationally recognized leader in that field."

Moylan will be surgeon-in-charge of the Emergency Department and director of the new Surgical Trauma Program in the Department of Surgery. He is an associate professor of surgery.

Sabiston said that Moylan will head a Trauma Unit

which will be established within the hospital and will contain special equipment for the treatment and monitoring of injured patients on a moment-to-moment basis, similar to Duke's cardiac care and acute care units.

* * *

Dr. Thomas D. Kinney has been honored by the American Society of Clinical Pathologists and the College of American Pathologists.

He received the ASCP-CAP Distinguished Service Award for outstanding contributions to American pathology.

Kinney is R. J. Reynolds Professor of Pathology, chairman-emeritus of the Department of Pathology and former director of medical and allied health education.

He was cited as a man "who has attained national recognition as an experimental pathologist, medical educator and medical editor." He has been editor-in-chief since 1967 of the *American Journal of Pathology* and he was the first editor of *Laboratory Investigation*.

* * *

A solid foundation on which to build world peace exists today in the "common problems and common language of health care" worldwide.

That opinion was expressed by Dr. William G. Anlyan, vice president for health affairs, in his presidential address to the Association for Academic Health Centers (AAHC). The AAHC is made up of persons who are the chief executive officers for academic health centers in the United States.

"It is inconceivable to me," Anlyan said in his address in Puerto Rico, "that countries that have so much in common in the provision of health care and the language thereof could be so far apart in the political arena and, at times, resort to unnecessary killing and bloodshed."

"If ever there were to be a successful ecumenical movement to provide the foundations for world peace," he said, "I would build it around the common problems and common language of health care."

Anlyan's talk was based primarily on personal observations made during visits to health centers and medical schools in Europe, Scandinavia, the Middle East, Great Britain and the Far East. He will go to China later this month.

While countries' health care problems may vary in degree, Anlyan said he believes most countries have the same major problems as the United States—access to primary health care, poor distribution of medical specialists and poor distribution of physicians geographically.

* * *

The Family Medicine Program has announced the establishment of a new program for placing students from out of state schools into clerkships in rural North Carolina. The program, which is supported in part by a

grant from the Department of Health, Education, and Welfare, began this summer.

According to Dr. Collin Baker, director of undergraduate programs in family medicine, clerkships with rural family physicians are in solo or group settings, and students are intimately involved in the life of a typical family doctor in a small town in either case.

They make hospital rounds, see patients in the office, accompany the doctor on house calls, and attend conferences in the local hospital. Students spend one or two days at the Family Medicine Center at the start and again at the end of their clerkship for exchange of information.

"Preceptorial locations for this program have been carefully chosen for the ability to present the student with a realistic exposure to a typical family practice in a small town, with emphasis on the preceptor's desire to teach and his ability to relate to undergraduates," Baker said. Students are selected without regard to their sex, race, school, or place of origin.

"The program is designed to help students who are seriously considering careers in primary care to gain the experience that will enable them to make wise decisions concerning such careers," he added.

* * *

Thirty-two of this year's 114 first-year medical students are from North Carolina. They are:

Claude S. Burton, III, David F. Colvard, Timothy R. S. Harward, Howard A. Lipton, Jon V. Martell,

David Mold, Thomas L. Novick, Reuben N. Rivers, Eric P. Smith, Christiane Stahl and Ronald L. Vereen from Durham.

Stuart R. Adler of Statesville, Charles S. Baker, III of Havelock, George T. Bartels of Chapel Hill, Edwin P. Bounous, Jr. of Morganton, Betty Bradley and William F. Cappleman, III of Carrboro, Ray Dawkins, Jr. of Fayetteville, Michael Dresser of Davidson, John G. Fitz of Hickory, Jerry M. Foster of Newton and David C. Jones of Mebane.

Edgar M. Kahn of Franklin, William N. Lane, Jr. of Winston-Salem, Philip N. Lister of Brevard, Samuel S. McCahren of Concord, Henry G. Marrow of Tarboro, Wayne K. Ruth of Raleigh, Richard K. Slate of Clemmons, Edward S. Stanton of Plymouth, William G. Ward of Lincolnton and Stephen C. Worsley of Greenville.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

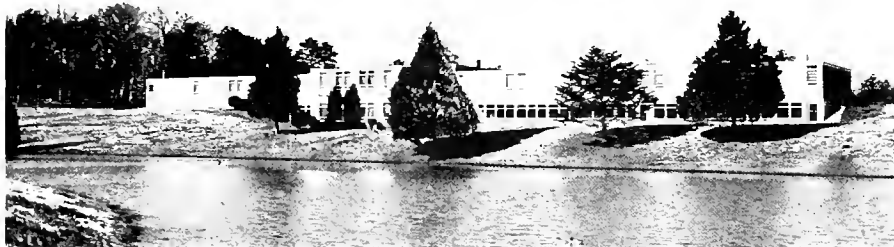
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ment began operation in the building in late September. It has 11 adult beds and six pediatric beds. All adult beds can be observed from a central nursing station.

The pediatric emergency area, the only one in the state, has its own nursing station.

The new emergency department has extensive X-ray equipment and has direct access to the surgical suite, the cast room and the physical therapy department.

The Department of Orthopedics moved into the building soon after the emergency medicine department.

In early October, the majority of the Medical Center's outpatient clinics moved into the new building, as did the radiation therapy section of the Department of Radiology and the physical therapy department.

* * *

North Carolina Baptist Hospital, the principal teaching hospital for the Bowman Gray School of Medicine, has opened a new 26-bed psychiatric unit.

The new facility replaces a 10-bed unit which had been used for several years.

The 26-bed unit, besides offering a more cheerful and modern environment, has examination rooms, a group therapy room, a larger nursing station, a nurses' lounge and a recreation therapy room.

* * *

The medical school has made 15 new appointments to its full-time and part-time faculty.

Receiving appointments were Dr. Horatio Van Cleve, associate professor of family medicine; Dr. Donald L. Evans, assistant professor of microbiology and immunology; Dr. Ann Herndon, assistant professor of psychology; Dr. Christine A. Johnson, assistant professor of pediatrics (hematology); and Dr. William H. Dodge, research assistant professor of medicine.

Appointed as instructors were Dr. Gretchen J. Belovicz, neuropsychology; Dr. Henry M. Chilton, radiopharmacy; Dr. John D. Davis, rheumatology; Dr. Herbert M. Floyd, anesthesia; Dr. Stephen W. Herbert, psychiatry; Dr. William J. Huff, radiation physics; Harriet Loucas, community medicine; Dr. James Mattox, psychiatry; Judith B. Soper, community medicine; and Donna Woodmansee, psychology.

Appointed to the part-time faculty were Dr. Ali Jarrahi, clinical assistant professor of psychiatry; Dr. John F. Benson, Dr. Theodore A. Keith and Dr. John R. Wolfe, clinical instructors in medicine; Dr. James E. Chapman, clinical instructor in obstetrics and gynecology; William F. Maready and James E. Sizemore, lecturers in medical jurisprudence; Dr. Thomas H. Milner, III, clinical instructor in radiology; Dr. Wesley F. Phillips and Dr. S. Leo Record, clinical instructors in family medicine; and Dr. William R. Proffit, lecturer in plastic surgery (orthodontics).

* * *

The California Association of Marriage and Family Counselors has honored Dr. Clark E. Vincent, profes-

sor of sociology and chairman of Bowman Gray's Department of Medical Social Science and Marital Health. It has permanently designated its annual award as the "Clark E. Vincent Award in Recognition of Scholarly Contributions to Professional Literature in the Field of Marriage, Family and Child Counseling."

Dr. Vincent was the first recipient of the award last year.

* * *

Dr. James G. McCormick, research associate professor of otolaryngology, has been awarded a three-year, \$164,382 grant to conduct research on the relationship between loss of hearing and atherosclerosis.

The grant is from the National Institute of Neurological Diseases, Communicative Disorders and Stroke.

The immediate goals of the research are to establish the connection between atherosclerosis and hearing loss, to determine how atherosclerosis contributes to hearing loss and to see whether a change in diet reverses damage to hearing.

* * *

Dr. Roscoe L. Wall, Jr., clinical professor of obstetrics and gynecology, has been re-elected chairman of the Sessions Management Committee of the American Fertility Society.

The society is composed of 5,000 obstetricians, gynecologists, urologists and other doctors located throughout the United States and in 34 foreign countries.

* * *

Three Bowman Gray faculty members have been given travel awards to support special study and attendance at international meetings in their respective fields.

The three are Dr. Eugene R. Heise, associate professor of microbiology; Dr. David L. Kelly, Jr., associate professor of neurosurgery; and Dr. Louis S. Kucera, associate professor of microbiology.

The travel awards program was established by the medical school three years ago to further the career development of outstanding young faculty members. The awards are made on the basis of scientific merit and the potential of the faculty member's proposed travel for career development.

* * *

Miss Peggy Wills has been named educational coordinator for the medical school's medical technology program.

She succeeds Mrs. Phyllis Newport, who retired from the post after 20 years with the medical school.

AMERICAN MEDICAL SOCIETY ON ALCOHOLISM

North Carolina physicians who are interested in any aspects of alcoholism are urged to join the American

Medical Society on Alcoholism, which already has a membership of more than 800 physicians. The society, established in 1967, has recently appointed state chairmen so that state branches can be established. The society is now a component of the National Council on Alcoholism and serves in a medical advisory capacity to the council.

The North Carolina branch is cosponsoring a meet-

ing on alcoholism to be held in Charlotte next January 28-30. Interested North Carolina physicians should contact their state chairman, John A. Ewing, M.D., Center for Alcohol Studies, Division of Health Sciences, University of North Carolina, Chapel Hill, North Carolina 27514. He can supply you with a folder giving more details as well as a membership application form.

Month in Washington

Members of the House Ways and Means Committee's subcommittee on health have heard testimony from foreign physicians extremely critical of the federalized national health insurance (NHI) systems in their native lands and from seven U.S. physicians who urged lawmakers not to allow this country to stumble down the same path.

All witnesses were selected by subcommittee Republican minority members to counterpoise arguments made by liberal witnesses produced during the summer by Democrat colleagues.

The major theme of the American physicians was that Federal interference should be kept to a minimum. Five of the seven physicians suggested that some form of catastrophic insurance might be beneficial.

Clinton S. McGill, M.D., Portland, Ore., told the subcommittee that "freedom within the widest possible latitudes in the practice of medical care is an ingredient absolutely essential to the success of any NHI program."

John Hamilton, M.D., Rochester, N.Y., urged elimination of administrative red tape and proposed a catastrophic plan based on patients' ability to pay.

Marvin N. Lymberis, M.D., Charlotte, N.C., also spoke favorably of catastrophic coverage, warning that an omnibus bill might bankrupt the government and leave the present health system in a shambles.

John Burkhardt, M.D., Knoxville, Tenn., said NHI must be carefully planned, cannot be all encompassing, and must not interfere with the doctor-patient relationship.

David Masland, M.D., Carlisle, PA., warned of a possible paper work explosion if NHI is enacted, urged use of private carriers rather than a Federal bureaucracy, and noted that social factors have the biggest impact on the health of the nation.

Brooker Masters, M.D., Freemont, Mich., said the nation does not have the resources at present for NHI. Rationing of services would be required, resulting in

"medical care dictated by edicts in the Federal Registry" which would lead to "chaos."

Donald Quinlan, M.D., Northfield, Ill., read a strongly-worded statement opposing any new Federal programs as "compulsory politicized medicine." He accused the Administration and Congress of the "great rip-off" of deficit financing.

The domestic panel was questioned by subcommittee chairman Dan Rostenkowski (D-Ill.) and Reps. John Duncan (R-Tenn.), James Martin (R-N.C.), and Philip Crane (R-Ill.). They praised the panel members for their testimony.

Asked by Rep. Charles Vanik (D-Ohio) to give a show of hands on how many would support a catastrophic plan, six of the witnesses raised their hands, but none did when he asked for their sentiments on catastrophic health insurance operated by Social Security. Vanik contended that the public is pushing Congress on NHI, asserting that the lawmakers are not the innovators.

The foreign panel consisted of two British physicians, a British medical writer, a former Swedish physician, and a Canadian physician—Max Gammon, M.D., London; Reginald S. Murley, M.D., London; Anthony Lejeune, Middlesex, England, medical writer; Sigmund J. Lofstead, M.D., Chicago; and Bette Stephenson, M.D., Toronto.

As a group they urged Congress not to permit governmental control of medicine in this country.

The British witnesses painted a black picture of the situation in England. Dr. Murley said almost all physicians in England are totally opposed to the policies of the government and predicted a "massive confrontation" soon.

Dr. Lofstead, who had practiced in Sweden, said health care has become regimented and politicized in that country. Most people in the U.S., he said, have financial access to the best and most sophisticated health care in the world.

Dr. Stephenson was less critical of the Canadian

program, but said any NH1 program should involve as little distortion of the present U.S. system as possible. She said fee-for-service is the most efficient and fairest method of payment.

Dr. Gammon said it is imperative that the U.S. resist the socialization of medicine "for the good of the rest of the free world." He said that "if you believe that the state is better able to control the affairs of individuals than they are, then the prospects of freedom for the rest of the world are very dim."

* * *

Despite continued optimism on the part of some members of House Ways and Means that a NH1 bill can be drafted this year, Capitol Hill oddsmakers are still betting it can't be done.

Besides the scarcity of time—at least 400 witnesses will be heard by Ways and Means alone—the jurisdictional battle between Ways and Means and House Commerce is far from solved.

Senior staffers of both committees are being quoted as saying "effective NH1 cannot come out of a Congress with the present messed-up jurisdiction" and "it simply can't be done in two committees."

Nonetheless, the chance always remains that House leadership under the pressures of an election year could knock heads together until a hurried bill was produced.

The Administration has opposed a domestic draft of young physicians for service in shortage areas and urged Congress to phase-out capitation grant support for the nation's medical schools.

Testifying before the Senate Health Subcommittee as it opened hearings on health manpower legislation, Theodore Cooper, M.D., Assistant Secretary for Health at the Health, Education and Welfare Department, said:

"We are seriously concerned that the general taxpayer—by means of federal taxes—will be called upon to subsidize in perpetuity the professional training of physicians, dentists, and other well-paid health professionals."

Dr. Cooper told the Subcommittee, headed by Sen. Edward Kennedy (D-Mass.), that legislation backed by Kennedy that calls for \$5 billion in aid over the next five years is "unnecessary to elicit adequate numbers of students for schools which today accommodate only one out of every two to three qualified applicants."

The Administration "strongly opposes" the compulsory service feature in the legislation requiring all graduates to serve in shortage areas. "This requirement could mean that in the very near future the federal government would have the responsibility for placing and monitoring the professional activities of thousands of individuals in the health system," Dr.

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Cooper proposed instead to strengthen the National Health Service Corps scholarship program.

The Assistant Secretary also attacked provisions imposing a federal regulatory scheme to control the numbers and allocation of training positions for graduate medical education and to institute a national licensure system for physicians and dentists. "We feel that there is little basis for initiating this far-reaching regulatory mechanism at this time," Dr. Cooper said.

By 1985 the U.S. will have from 207 to 217 physicians per 100,000 population, he testified, placing this nation "near the top of all the industrialized nations in terms of overall physician supply."

* * *

The president of the American Insurance Association believes it may become necessary to separate two elements involved in the medical malpractice insurance system—the compensation of those who suffer loss because of a doctor or hospital fails to perform in accordance with acceptable standards of practice, and the incentive for, and discipline of, medical practitioners.

T. Lawrence Jones said "we think that the public will resist limitations on their legal rights unless coverage for the patient is improved in some other respect and some substitute measure for disciplining doctors and hospitals is created."

Jones, whose association includes many of the firms that write professional liability, said divorce of the two functions "will not be an easy job."

He told a National Press Club breakfast in Washington, D.C., that no one yet knows what the outlines of the two replacement systems should be, let alone the specific features of either. Many trade-offs will be necessary. Cooperation among the professions will be essential. But the present problems with medical malpractice insurance is so complex and so full of implication for the overall health care of the public that bold solutions of all kinds must be pursued.

Jones said he believes that Professional Standards Review Organizations (PSRO's) offer a promise of ameliorating the malpractice crisis.

* * *

Scores of health organizations have protested loudly to Congress about the red tape and inequities in the Medicare program and have urged the Ways and Means' subcommittee on health to straighten out the mess.

The Subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), called two days of hearings to consider the flood of complaints about HEW's regulatory operations over the past year. The Subcommittee is expected to draft legislation to correct some of the trouble spots identified at the hearings.

The American Medical Association declared "the continuing frustrations of the public and the economic limitations on resorting to the courts for all remedial action must be viewed seriously by this subcommittee and this Congress."

Edgar T. Beddingfield, M.D., Vice Chairman of the

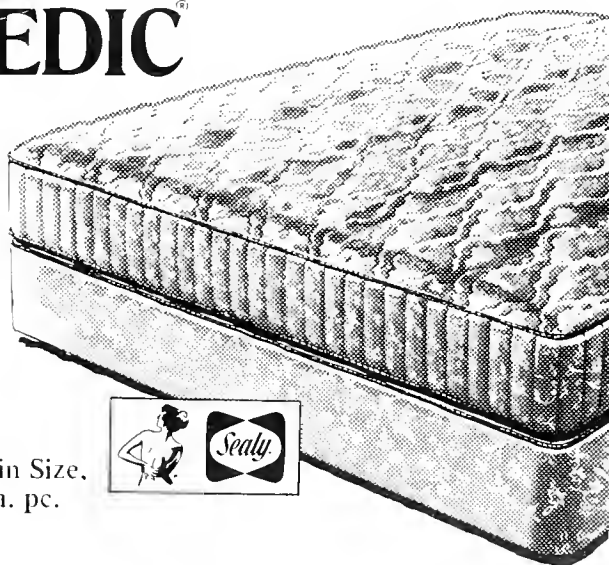
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AMA's Council on Legislation, referring to HEW's index for figuring physicians' fees under Medicare, said "if the administrative process is to be unbridled and is to be permitted to disregard the rights of individuals and arbitrarily to establish essential factors without adequate compliance with the law, then a discussion of the provisions enacted by Congress in essence becomes moot."

Charging "abuse of the regulatory process" by HEW, Dr. Beddingfield said effects of the economic index will be to lower reimbursement rates for many procedures below the rates recognized by the program in fiscal 1975."

The 1972 Social Security Amendments Law which set Medicare payment controls at the 75th percentile with future adjustments tied to an index determined by HEW is "clearly discriminatory," the AMA witness said. "We are not aware of any segment of society against which similar controls are imposed by Congress." Upshot of such controls, he warned, "will be to shift an increasing financial burden on the beneficiaries."

Dr. Beddingfield urged acceptance of the AMA's 19 amendments to the Professional Standards Review

Organization (PSRO) program and postponement of the Jan. 1, 1976, deadline for professional associations to form PSRO's.

C. Willard Camalier, M.D., Chairman of the AMA's Council on Medical Service, described the AMA's court fight and negotiations with HEW over utilization review in hospitals. He asked repeal of the law's provisions dealing with UR on the subject of the Medicare end stage renal disease program.

Dr. Camalier said "Medicare has attempted to interfere with the practice of medicine by interposing itself between the patient and the physician by refusing to recognize that services for kidney treatment should be reimbursed in a manner consistent with other physician services, and that local determination and medical review are not only preferable, but also the only feasible program for provision of any medical service." This program emphasizes the difficulties encountered when a disease category is made the basis for Medicare coverage.

The provision authorizing HEW to mandate "reasonable costs" for hospitals gives the government the right to determine in effect whether services are medically necessary, the AMA official said. "We must



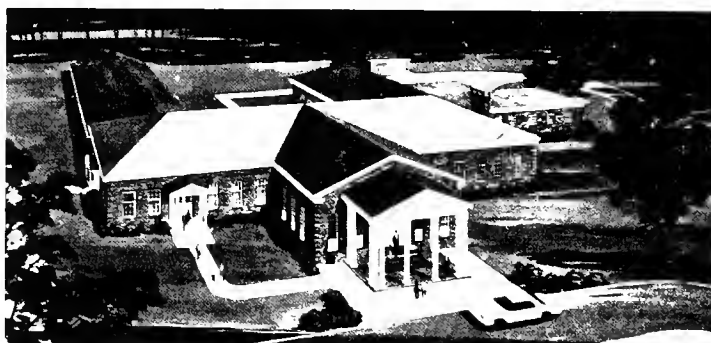
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adamantly object to any attempt on the part of the HEW Secretary to make determinations as to the necessity of health care services required in proper patient care."

* * *

A practicing physician has told Congress that pending lobbying legislation would go far in discouraging valuable communications to Congress from medical professionals and from patients.

Alvin Goldfarb, M.D., St. Louis, Mo., obstetrician-gynecologist, said as a physician he has an interest in a wide range of health legislation and regulations which have "a marked influence, whether favorable or unfavorable, upon my own, as well as that of all other physicians' practice."

He told a House Judiciary subcommittee that under proposals to tighten the lobby-laws "I could be considered a lobbyist, and would have to provide detailed quarterly reports. My failure to comply could result in fines or jail sentences."

The physician said the bills define lobbying as a communication with Federal officials, either legislative or executive, to influence the policy-making process.

Said Dr. Goldfarb:

"I can assure you that I as a specialist and practicing physician have a great interest in those Federal pro-

grams that affect my practice. I have an interest not only in how they impinge on my manner of practice but also in how they affect my patients as beneficiaries of the programs."

"I feel as if it is my right as a individual, as well as my duty as a physician, to communicate with members of Congress and with the bureaucracy and at times to urge others to do so to make my voice heard in the legislative and regulatory process which will affect, either favorably or unfavorably, my practice or my patients. I am sure you would agree with me that when physicians seem to get the legislative process in order to protect or to improve the state of health care, this is a goal which should not be threatened by obstacles."

Dr. Goldfarb asked "on whom would the burden of complying really fall, the professional lobbyist or the inexperienced, non-professional individual who would be a lobbyist only because of the broad definition of the bill? Who really needs to be regulated, the person who for pay can lobby on any subject or a member of the public who has a vast reservoir or experience in his own field and who is willing to share this information in an attempt to assure intelligent legislation? Would I be considered a lobbyist if I urge my patients to write their Congressmen concerning legislation or to the bureaucracy concerning regulations?"

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Book Reviews

Review of Medical Physiology. 7th edition. 587 pages. Price, \$10.50. By William F. Ganong, M.D. Los Altos, California: Lange Medical Publications, 1975.

Review of Physiological Chemistry. 15th edition. 570 pages. Price, \$10.00. By Harold A. Harper, PhD. Los Altos, California: Lange Medical Publications, 1975.

Practical Psychiatry for the Primary Physician. 357 pages. Price, \$15.00. By James R. Hodge, M.D. Chicago, Illinois: Nelson-Hall, Inc., Publishers, 1975.

So many paths are open to the medical graduate that years later many of us wish we could travel down the road not taken, if only to reassure ourselves that we made the wise choice. The only way short of fantasy really open to us is by reading and the very volume available covering a particular field usually prevents such mental trips. Still if we are tempted, Lange Publications, quietly, has been offering frequent editions of short, well-organized, pertinent reviews of the medical specialties and of the basic sciences for many years. For those who complain about still wanting to understand physiology just a little better, the seventh edition of *Review of Medical Physiology* by Ganong, a

single author effort, is a best buy — up to date, well-illustrated, economically written and economically priced. Unfortunately, its running mate, the fifteenth edition of *Review of Physiological Chemistry* by Harper, isn't up to the usual Lange standard. Several sections, particularly about renal function and water and mineral metabolism, read as if their silver anniversaries had passed without revision. All the metabolic flow and enzyme diagrams are there but I would wait until the deficient chapters were modernized before buying.

For those seeking a review of psychiatry for the non-psychiatrist, Hodge's *Practical Psychiatry for the Primary Physician* is highly recommended. Well-written, comprehensive, reasonable, eclectic, it lacks only chapters about patient reaction before and after surgery and on the psychodynamics of specialty choice by physicians to be valuable for any physician.

JOHN H. FELTS, M.D.

In Memoriam

NATHAN ANTHONY WOMACK, M.D.

Dr. Nathan Anthony Womack, Kenan Professor Emeritus and Chairman Emeritus of the Department of Surgery at the University of North Carolina School of Medicine, died in Chapel Hill, February 2, 1975.

Dr. Womack was born May 24, 1901, in Reidsville, North Carolina. He completed his undergraduate education and the first two years of medicine at the University of North Carolina in 1922, receiving the B.S. in Medicine degree. In 1924, he was awarded the M.D. degree from Washington University School of Medicine. He served his surgical residency at Barnes Hospital in St. Louis from 1924 to 1929. During 1929-30, he held a traveling European fellowship in surgery.

Dr. Womack was appointed to the faculty of the Washington University School of Medicine in 1930 as an assistant in surgery and for the next 17 years rose through the various academic ranks to clinical professor of surgery. During these years he was a member of the surgical staff of Barnes Hospital. In addition he became an accomplished surgical pathologist, correlating microscopic morphology with the clinical manifestations of disease.

In 1948, he accepted the professorship of surgery and chairmanship of the department at the University of Iowa School of Medicine. He held this position until 1951, when he returned to the University of North Carolina School of Medicine as its first professor and chairman of the department of surgery in Chapel Hill. In 1967, he retired as chairman, but he continued to be active in teaching and in research until his death.

During his long and distinguished career in medicine, Dr. Womack held numerous visiting professorships at other universities and was a member of many professional societies and organizations, includ-

ing the American Surgical Association (first vice-president, 1961; secretary, 1948-54) and the American Board of Surgery. He was past president of the National Board of Medical Examiners and a member of its executive board. Dr. Womack served on the editorial boards of the *Annals of Surgery*, the *American Surgeon* and the University of North Carolina Press. He was the author or co-author of 112 scientific publications. He was listed in the *American Men of Science*, 1960; *Who's Who in America*, 1952; *Men of Achievement*, 1974; *The World Who's Who of Authors*, 1975.

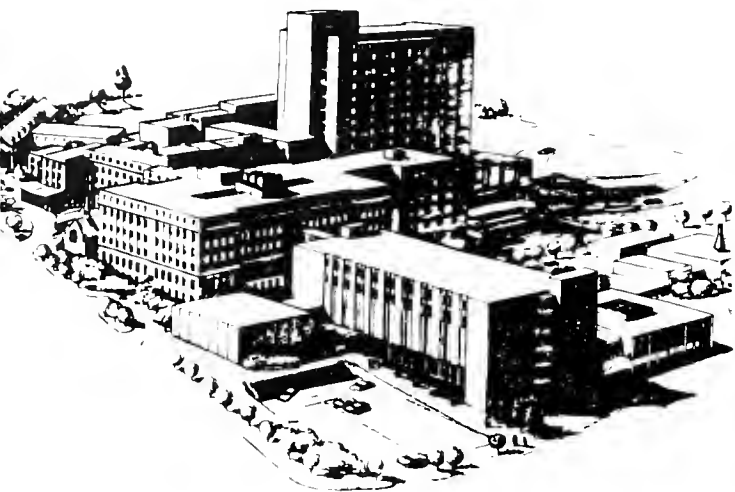
Many honors came to Dr. Womack. He was a member of the Order of the Golden Fleece (UNC) and Alpha Omega Alpha (Washington University). In 1963, he was made Kenan Professor of Surgery. In 1967, he received the Distinguished Alumni citation from Washington University, and in 1974 the University of North Carolina School of Medicine awarded him its Faculty-Alumni Distinguished Service Award. He was honored by his colleagues and former residents in 1969 by the establishment of the Nathan A. Womack Surgical Society.

Dr. Womack was recognized as a national leader in the fields of surgery and medical education. He was loved and held in utmost esteem by his students, colleagues and patients, and has been described, "as always a provocative teacher, an imaginative and critical thinker. He was the epitome of an academic surgeon."

Dr. Womack is survived by his widow, Mrs. Margaret Richardson Womack, a son, James Anthony Womack of New York, and a daughter, Mrs. Thomas A. Hruska of Marquette, Michigan.

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NORTH CAROLINA

Medical Journal

IN THIS ISSUE: Management of Reflux Esophagitis With Stricture, Gordon F. Murray, M.D., Lewis E. Williams, M.D., Benson R. Wilcox, M.D., and Peter J. K. Starek, M.D.; Abdominal Trauma As a Cause of Fetal Death, E. C. Garber, Jr., M.D.; Anton Chekhov: A Physician-Genius in Spite of Himself, Part III, Richard E. Cytowic

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Management of Reflux Esophagitis With Stricture

Gordon F. Murray, M.D., Lewis E. Williams, M.D.,
Benson R. Wilcox, M.D., and Peter J. K. Starek, M.D.

BENIGN fibrous stricture of the esophagus is the result of esophagitis due to reflux through an incompetent cardia. While bouginage may offer temporary relief, the development of stricture should be considered an indication for surgical intervention in most instances. The early work of Lucius Hill¹ and, more recently, Herrington and associates² suggest it is possible to dilate a stricture effectively and prevent its recurrence by using one of the sphincter enhancing funduplications. This report assesses this simplified technique used in the management of 15 patients with esophageal stricture complicating reflux esophagitis at North Carolina Memorial Hospital.

METHODS AND MATERIAL

Twelve of the 15 patients were male. Ages ranged from 13 months to 63 years, with a peak incidence in the fifth decade. Progressive dysphagia was a prominent symptom of all 15 patients at the time of operation (Table 1). Most patients suffered from heartburn and regurgitation for many years before developing dysphagia. Weight loss during the year before surgery was a dominant symptom in nearly half the patients. Four patients had experi-

enced intermittent hematemesis and two developed complications of chronic pulmonary aspiration.

Barium contrast studies demonstrated esophageal stricture in all patients and a discrete ulcer was seen in four. An associated sliding hiatal hernia was identified in 13; although reflux was radiographically demonstrated in only six. Associated duodenal ulcer disease was noted in four.

Esophagoscopy confirmed the stricture in all patients. A very high (19 cm) stricture was seen in a one-year-old child. The remaining 14 strictures were equally distributed in the mid and lower thoracic esophagus. Eleven patients had severe ulcerative esophagitis as well as stricture. Three had a columnar-lined lower esophagus — so-called Barrett's epithelium. An incompetent lower esophageal sphincter was identified by manometric examination in 10 patients; a normal resting sphincter pressure in three. In two patients, the manometry catheter could not be passed beyond the stricture.

Intraoperative dilation of the stricture was possible in every patient (Table 2). A transthoracic anti-reflux fundoplication was then done in nine patients. An abdominal approach was selected for four because of coincident duodenal ulcer disease requiring vagotomy and pyloroplasty. In two patients, an esophageal lengthening procedure (Collis gastroplasty) achieved a re-

pair free of tension. In fact, this operation was selected to manage our only recurrence of a transthoracic repair.

RESULTS

Twelve (80%) of the patients were entirely free of symptoms one to 27 months after operative dilation and fundoplication. Two patients had mild dysphagia improved by one to three postoperative dilations. One patient with advanced arteriosclerotic heart disease enjoyed complete relief of esophageal symptoms but died suddenly at home a week after discharge. Myocardial infarction is suspected, but no autopsy was obtained. Radiographic resolution of stricture with satisfactory prevention of reflux has been remarkable. A typical

Table 1
Clinical Features of Esophageal Stricture (15 patients)

Symptom	No. Patients	Avg. Duration (yrs.)
Dysphagia	15	4
Heartburn	11	14
Regurgitation	9	9
Weight Loss	7	1
Hematemesis	4	—
Pulmonary	2	—

Table 2
Operative Procedures

Procedure	No. Patients
Operative Dilation	15
Belsey Mark IV	9
Hill (Vagotomy-Pyloroplasty)	4
Collis-Belsey	2

From the Division of Cardiothoracic Surgery, University of North Carolina School of Medicine, Chapel Hill, North Carolina 27514.

Reprint requests to Dr. Murray.



Fig. 1. Radiographic resolution of esophageal stricture with satisfactory prevention of reflux is demonstrated by preoperative (A) and three months post-repair (B) barium swallows.



Fig. 2. Barium swallow shows excellent compression of the long intra-abdominal segment of esophagus by the Belsey fundoplication.

barium swallow before and after surgery is shown in Figure 1.

DISCUSSION

In the past, surgical therapy for esophageal stricture at North Carolina Memorial Hospital has been resection of the damaged segment and reconstruction. These operations have included small bowel interposition between distal esophagus and stomach, short segment colon interposition and other complex and high-risk procedures. Because of the magnitude and morbidity of resection and interposition operations, the present approach — operative dilation and fundoplication — was considered.

The Belsey Mark IV trans-thoracic repair of hiatal hernia is preferred in our clinic³. This approach offers excellent exposure through a left sixth interspace lateral thoracotomy. Complete mobilization of the esophagus to the hilum of the lung allows reduction without tension. The anatomic plication has been technically simple and functionally effective. The mechanism by which fundoplication succeeds in preventing reflux is not clear, but simple mechanical factors, as well as sphincter enhancement, probably are involved⁴. Maintenance of an intra-abdominal segment of the esophagus compressed by positive abdominal pressure is probably an important element in the control of reflux (Figure 2).

An important feature of this approach is the ability to dilate the esophageal stricture under direct

vision. The esophagus and cardia are first mobilized, and per-oral dilation accomplished to a size 40 French in the adult with Maloney dilators. With the esophagus in the operator's hand, the mercury-filled bougie can be guided through the stricture and the risk of unrecognized perforation avoided. Operative dilation was successfully performed in every patient in this report (Table 2).

Acquired shortening of the esophagus does not prevent reconstruction of the cardia by the Belsey technique. In two of our patients, an esophageal lengthening procedure (Collis gastroplasty) was combined with the Belsey procedure to achieve a repair free of tension. The gastroplasty technique of Collis achieves esophageal lengthening with an incision in herniated stomach made parallel with the lesser curvature⁵. The result is a gastric tube extension of the esophagus. The Belsey plication can then be done without tension, placing sutures in the new distal esophagus.⁶

SUMMARY

Development of esophageal stricture due to reflux esophagitis should be considered an indication for surgical intervention in most instances. Operative dilation and competence-restoring fundoplication offers technically safe and functionally effective management. Trans-thoracic operative exposure allows complete mobilization of the esophagus and dilation of the stricture under direct vision has been uniformly successful. Although reduction of the esophagogastric junction is usually possible, an esophageal lengthening procedure may be necessary to achieve tension-free reconstruction of the cardia.

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Abdominal Trauma as a Cause Of Fetal Death

E. C. Garber, Jr., M.D.*

INTRODUCTION

FETAL death due to maternal abdominal trauma is unusual unless associated with maternal death, penetrating wounds, severe displaced pelvic fractures, uterine rupture, placental separation or severe maternal shock with poor placental perfusion. In fact, it is assumed that without direct uterine injury, the fetus will survive an accident if the mother survives.

Poulson and Gabert¹, Dyer and Barclay², and Raney³ have reported fetal death due to trauma without serious maternal injury. The cause of death was thought to be skull fracture in one case and intracranial hemorrhage in the other two. Raney's case involved a lap seat belt thought to be the cause of fetal death. Pike⁴ reported an intrauterine depressed skull fracture due to a fall. Delivery was spontaneous 13 days later. Surgical elevation of the fracture showed evidence of old fracture.

This report adds two cases of fetal death without serious maternal injury or uterine rupture and one case of ruptured uterus, reported because of its unusual cause.

CASE ONE

Mrs. D. M., age 19, primigravida, 36 weeks pregnant was admitted February 9, 1963. Shortly before admission she drove her automobile into the rear of another car and received a direct blow to her abdomen from the steering wheel. She was not using a lap seat belt. She was admitted for observation although there was no apparent injury. The next morning the uterus was irritable and the fetal heart could not be heard. A large area of ecchymosis was present on the patient's abdomen. There was no evidence of placental separation. Since the cervix was unfavorable, she was discharged.

The patient was readmitted on February 19 for induction of labor. Labor promptly followed amniotomy and a four pound and one-half ounce macerated fetus was delivered. Autopsy showed hemorrhage in the retrosternal tissues, pericardium, thorax bilaterally and diaphragmatic pleura. This patient has since delivered three normal infants.

CASE TWO

Mrs. M. K., age 29, para one, 34 weeks pregnant was admitted October 15, 1967, because of labor. Four days earlier she had been in an auto accident and received a direct

blow to the abdomen from the steering wheel. She was not using a lap seat belt. She did not feel fetal activity after the accident, but she did not report this and did not seek examination. After a short labor she delivered a five pound two ounce stillborn fetus. Autopsy showed fracture of the occipital bone with hemorrhage in the brain and scalp. This patient has since delivered a normal infant.

These two cases emphasize the danger to the fetus in automobile accidents in which there is only slight trauma to the mother, although Crosby and Costiloe⁵ have reported the most common cause of fetal death in accidents to be the death of the mother. When the mother survived, placental separation was the most frequent cause of fetal death. The maternal pelvis may be fractured and displaced, causing fetal death without injury to the uterus as reported by Theurer and Kaiser⁶.

The pregnant woman near term is awkward and falls are common, although they rarely cause fetal injury. Examination, reassurance and symptomatic treatment is usually sufficient. The pregnant uterus is so prominent near term that it may be subjected to all types of trauma. The review of Dyer and Barclay² describes the various injuries that oc-

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cur. Griswold and Collier⁷ reviewed blunt abdominal trauma and found that visceral injury from nonpenetrating abdominal trauma has increased progressively with the incidence of traffic accidents. The most frequent injury to the pregnant uterus was rupture.

In the following case of ruptured uterus, the mother had no other injury.

CASE THREE

Mrs. M. R., age 19, primigravida at term was admitted October 7, 1966, shortly after an auto accident. She was in the front seat between her husband and a friend. Their car was hit on the left side and she was "sandwiched" between her husband and friend. Examination revealed a ruptured uterus. The fetal heart rate was 30 to 50 a minute. Immediate laparotomy revealed a low transverse rupture of the uterus. A stillborn fetus weighing seven pounds nine ounces and the

placenta were free in the abdomen. Bleeding was minimal.

In automobile accidents the pregnant uterus may be damaged by direct trauma from the steering wheel, by sudden compression by a lap seat belt or from other passengers, as in case three.

Some have advocated that lap seat belts should not be used by pregnant passengers since it might increase fetal deaths rather than reduce them. In a study by Crosby, King and Stout⁸ there was no significant change in maternal or fetal death rates when passengers used or did not use lap seat belts. However, ejected passengers had a higher fetal and maternal death rate than those who remained within the vehicle.

The detailed animal experiments of Crosby et al⁸ concluded that "prevention of forward flexion by a shoulder harness offers significant protection for the fetus as well as the mother and should be recommended for the pregnant traveler."

The lap seat belt should also be used—placed snugly across the pelvis and not over the fundus.

COMMENT

Pregnant patients near term who suffer blunt abdominal trauma should be examined. If there is any suggestion of uterine injury, fetal damage or placental separation, the patient should be admitted for observation and indicated laboratory and diagnostic procedures carried out. Fetal monitoring will help to save an occasional involved fetus.

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"This is why I made up my mind to be a physician," said the culprit; and though she had been looking down and growing more uncomfortable every moment, she suddenly gave her head a quick upward movement and looked at Mrs. Fraley frankly, with a beautiful light in her clear eyes. "I believe that God has given me a fitness for it, and that I never could do anything else half so well. Nobody persuaded me into following such a plan; I simply grew toward it. And I have everything to learn, and a great many faults to overcome, but I am trying to get on as fast as may be. I can't be too glad that I have spent my childhood in a way that has helped me to use my gift instead of hindering it. But everything helps a young man to follow his bent; he has an honored place in society, and just because he is a student of one of the learned professions, he ranks above the men who follow other pursuits. I don't see why it should be a shame and dishonor to a girl who is trying to do the same thing and to be of equal use in the world. God would not give us the same talents if what were right for men were wrong for women."—*A Country Doctor*, Sarah Orne Jewett, 1884, pp 281-282.

ANTON CHEKHOV: A Physician-Genius In Spite of Himself Part III

Richard E. Cytowic

RETURN TO RUSSIA

ANTON CHEKHOV continued his return trip via a circuitous Far Eastern route, arriving in Russia in December, 1890, with ambivalent feelings. "I have lived," he wrote, "I was both in Hell, as represented by Sakhalin, and in Paradise—i.e. on the island of Ceylon." As for the Hell, he complained of a "certain bitterness in my innards, as if from rancid butter," and as for Paradise, boasted of relations with a black-eyed Hindu maiden in a moonlit coconut grove. He continued this wayward life, leaving in March on a tour of Western Europe with Alexis Suvorin. His return to Russia was heralded by severe attacks of migraine, violent coughing spells, and now, heart palpitations. His illness quickly sent him into another depression:

I always feel that my trousers don't fit right, that I'm not writing as I should, and that I give my patients the wrong powders. It's probably a psychosis (August 30, 1891).

In the spring of 1892 Chekhov moved his entire family to a new 600-acre country estate, Melikhovo, near Moscow. He expected

that the quieter pace would benefit his health and permit more time for writing. Word spread quickly of his presence in the relatively doctorless district, and he was constantly besieged by patients, some of whom came from as far as 15 miles. Since both his time and pharmaceuticals were given gratis, he was forced to write for an income. He had also anticipated fewer visitors in the country, but his incredible knack for being surrounded by friends assured just as many guests as there had been in Moscow. They were also harder to get rid of.

Because of his reputation for hard work, medical acumen and *sos-tradanyie* (compassion), Chekhov was installed by the *Zemstvo* as district health officer during the July cholera epidemics. His section included 25 villages, four factories and a monastery. It was considered exemplary in having one doctor (Chekhov), a medical assistant and two barracks (which were built by contributions from neighboring manufacturers since the *Zemstvo* provided no money at all for expenses). In addition to cholera, there were concurrent epidemics of typhus, diphtheria and scarlatina. From August to October he registered more than 1,000 patients, documenting 11 cases of cholera.

These cases he called "the blossoms," forecasting that "the berries will come in the spring." The peasants practiced poor sanitation and were coarse and mistrustful. But they had by this time become so used to medicine that it was hardly necessary to convince them that the physicians were not to blame for the cholera. Chekhov prophesied that in all probability "they won't beat us up" (July 22, 1892).

It must have been tedious to think of nothing but diarrhea for four months. In the infancy of bacteriology, infectious diseases provided a sense of challenge, even excitement, to these frontier doctors. During the impending epidemic Chekhov wrote:

One must expect it any hour. To judge by its progress in Moscow one must regard it as declining and assume that the Comma is losing its virulence. The intelligentsia works briskly, sparing neither life nor money; I see it every day and am touched. In the good old days, when thousands sickened and died, men could not so much as dream of the overwhelming victories that are now being achieved before our eyes. It is a pity that you are not a physician and cannot share my gratification—that is, truly feel deeply and realize and evaluate all that is being done (August 16, 1892).

Waxing philosophic, he speculates on the purpose of disease and the wisdom of nature:

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The bibliography will appear at the end of the fourth installment

Nature is obviously straining every nerve to get rid of debilitated organisms and those she doesn't need. Famines, cholera, influenza, . . . Only the strong and healthy will remain. But to reject the doctrine that there is a purpose in things is impossible. Our starlings suddenly flew away somewhere, baffling because the time for migration is still far off. Unexpectedly, we learned that clouds of southern dragonflies, mistaken for locusts, had flown across Moscow. How did our starlings know that on such-and-such a day, miles from Melikhovo, multitudes of insects would be flying? Verily this is a great mystery, but a wise one. The same wisdom is hidden in famines and the illnesses that succeed them. We and our horses represent the dragonflies; famine and cholera the starlings (May 28, 1892).

During the cholera epidemic a private disease struck Chekhov's Melikhovo: "Impecuniousness." Receiving no monetary recompense for his work as either a private physician or the district cholera doctor, Chekhov was forced to rely on literature for support. During this period he wrote some of his best known stories: "My Wife," "The Black Monk," "Neighbors" and "Ward No. 6." He was again poised between two poles of identity, physician vs. writer. He admitted that caring for the sick night and day was three times easier to bear than discussions of literature with visitors in Moscow, but dreadfully wanted a vacation from both. Worst of all was a constant concern for money:

My soul is wasted away because of the awareness that I am working for the sake of money, and that money is the center of my activity. I have no respect for my writing. I am listless and bore my own self, and am glad that I have medicine which, no matter what, I am following not for the sake of money, after all. Really, one should take a bath in sulphuric acid, peel off one's skin, and grow new wool (June 16, 1892).

In reality, he was constantly "growing new wool," always engaged in several projects at any given time. He was involved in the census of 1897. He volunteered to organize the construction of three schools in the outlying villages during 1895 to 1898. He was extremely proud of them and was able to write that the *Zemstvo* considered them model buildings. Chekhov also founded *Annals of Surgery* (circa 1894), which was edited by Sklifasovsky and Dyakonov, two

well-known surgeons and scientists of the time. Chekhov vowed that it was superb in its scientific content, and "an altogether European publication." It ran into financial difficulties in 1896 and his vigorous efforts managed to keep it afloat until nearly 1898. His attitude in wanting an organ for communication of new surgical techniques is reflected in his statement that a good surgical journal was just as useful as performing 20,000 successful operations.

Also during this period Chekhov was writing his second play, *Chayka* (*The Sea Gull*), which was a fiasco at its premiere in October of 1896. He soon became a close acquaintance of novelist-playwright-stage director V. I. Nemirovich-Danchenko and acting teacher-theoretician K. S. Stanislavsky, who together founded the Moscow Art Theater in 1898. This prestigious company gained worldwide recognition as the definitive performers of Chekhov's plays (although Chekhov firmly believed that Stanislavsky never really understood his plays).

In March of 1897 and August of 1899, the seriously ill physician again put aside his own concerns for those of others to work during the plague epidemics. Even without plague, the populace had a high mortality rate from the rigors of country life and poor sanitation. Chekhov was optimistic that it would soon be eradicated and cited the work of Vladimir Khavkin (1869-1930). Completely unknown in his own country, this Russian-Jew worked at the Pasteur Institute, which sent him to India to study cholera and Bubonic plague. Around 1890 he introduced anti-plague serum, with which eight million Hindus were inoculated. The suspicious natives detested him, and in several backward areas almost murdered Khavkin and his associates. Concerning plague, Chekhov writes:

It will not likely frighten us much, since both the populace and physicians have long since become inured to the sudden incidence of mortality, thanks to diphtheria, typhus, etc. Even without plague we have barely 400 out of 1,000 children surviving to the age of 5, while both in the villages

and factories, and back streets of the cities you will not find one woman in sound health. The frightening thing about plague is that it will appear two or three months after the taking of the census; the peasants explain it their own way. 'They're poisoning off all the extra people, so's there will be more land for the masters.' A certain hope is being offered by Khavkin's inoculations, but he is not popular in Russia: he's a Yid. (January 17, 1897).

He was immersed in cholera, typhus and plague and was forced to be totally indifferent to the patients, who didn't have a cent. Perhaps it was inundation with others' illnesses that finally caused him to admit his own. His first acknowledgement is found in reply to a friend's offer of a red-hot marriageable girl:

Do excuse me: I cannot marry at the present because, first of all, I have bacilli squatting in me, which are very disreputable tenants (December 18, 1896).

TUBERCULOSIS, MARRIAGE AND DRAMA

On March 20, 1897, while dining with Suvorin at the Hermitage Restaurant in Petersburg, blood gushed out of Chekhov's mouth just as he had begun to eat. The ice which was applied had little effect and he was taken to the hospital of the University of Moscow for two weeks. It was here that he consented to be examined for the first time; as did Cato the Elder, Chekhov believed more in cabbage than in doctors. He now had little excuse to conceal his disease from himself or others. The doctors unanimously diagnosed extensive apical pulmonary tuberculosis and forbade him, thenceforth, "almost everything interesting." As one might expect, this beloved man was immediately and constantly surrounded by family and friends. Ironically, he proposed getting married, suggesting that an ill-natured wife would be able to reduce the number of his visitors to half.

He was at the time under the care of his friend Altschuler, a Russian-German tuberculosis specialist. His initial treatments consisted of creosote vapor inhalation and the application of a poultice. He expressed much hope in experiments with Koch's preparations of tuberculin and even considered a

trip to Berlin for treatment. Koch isolated the tubercle bacillus in 1882 and made his famous address to the International Physiologic Congress at Berlin in 1890. His premature announcement of tuberculin as a cure for tuberculosis was a statement he was to regret the rest of his life.

The change of lifestyle ordered by his physicians required much adjustment for Chekhov and included his retirement from active medical practice. "By order of my colleagues," he wrote in May of 1897, "I lead a boring, sober, virtuous life." The partial answer to his boredom was another change of scene, this time Yalta on the southern coast of the Crimea. Moving from one area of the country was in vogue then, the theory being much the same as advocating Arizona for sinusitis today. It is doubtful whether this translocation ameliorated his physical condition; it certainly did not help his mental state. He was faced with the reality of "being in exile" from his friends, the theater and the city life that he loved so dearly. He was strictly forbidden to visit Moscow or Petersburg and had to accept life in the country, where even the bacilli were asleep.

I have been uprooted from my native soil. My life is incomplete. I don't drink, although I like drinking. I like it when it is noisy, but I don't hear any noise. In a word, I now endure the condition of a transplanted tree which hesitates between taking root and starting to wither away (February 10, 1900).

To assuage his boredom, an unexpected incident soon befell him, namely, marriage to Olga Knipper (1868-1959), a leading actress of the Moscow Art Theater. Chekhov first met her on September 9, 1898, at a rehearsal of *The Sea Gull*. They endured a long courtship, finally marrying on May 25, 1901. The wedding was secret. Chekhov was fearful of the ceremony, congratulations "and the champagne that you must hold in your hand while you smile vaguely." They were married en route to Ufa, where Chekhov was to take the *Kumiss* cure (a beverage made from fermented milk). They

honeymooned in the sanitarium.

At the age of 41, Chekhov claimed that marriage was hardly noticeable ("like a little bald spot," he said), but it affected his life profoundly. Since Olga was usually in the capitals and he was cooped up in Yalta, they exchanged letters almost daily, their notes accounting for the bulk of his correspondence from 1901 to 1904. In addition to a certain fulfillment by which Chekhov now felt whole, the marriage caused an abrupt change of an accustomed peaceful existence. His condition steadily declined during their four years together. Against doctor's orders, he constantly visited Moscow, threw and attended parties with his friends and exerted himself for Olga. His last play, *Vishnyovy Sad (The Cherry Orchard)*, premiered at the Moscow Art Theater on January 19, 1904. His friends used this occasion to celebrate his 25th anniversary as a writer (although Chekhov clarified that it was in 1880, only 24 years previously, that his first pieces appeared). The performance was a tremendous success that received thunderous ovations and much foot-stomping. The author was called on stage after Act III and lauded with twelve speeches by his *bon autres*. He barely had enough strength to stand during these ceremonies.

In June, he and Olga traveled to Badenweiler, a health resort in the Black Forest of southern Germany. In his last letter, addressed to his sister Masha, Chekhov wrote of his hopeless, frustrating condition. The tuberculosis had spread to his intestines, making his gastrointestinal ailments of so many years' duration unbearable:

Obviously my stomach is in a hopeless condition, and there is no help for it by any means short of fasting, that is, to stop eating entirely—and that's final. Basta! As for my shortness of breath, the only remedy is not to move (June 28, 1904).

On his final day, July 1, 1904, both he and Olga had not heard the evening dinner bell. They sat quietly in the hotel room, she absolutely unaware that the end was so

near. He invented a story—his last one—which shortly had Olga rolling on the couch with uncontrollable laughter. He later asked for Dr. Schwörer, head of the sanitarium. The doctor did not arrive until 2 a.m., by which time Chekhov was dyspneic and delirious with fever. He refused an attempt to put an icebag on his chest, saying that "one doesn't put ice on an empty heart." With almost an ironic politeness, he sat up in bed and announced to Dr. Schwörer, in bad German, "*Ich sterbe*." Schwörer immediately gave him a camphor injection as a pressor agent, but when this failed, he sent for oxygen. With perfect calmness, Chekhov informed him that he would be dead by the time it arrived and that he preferred champagne instead. Turning to Olga, he smiled and said "I haven't had champagne in a long time." He drank it slowly, then stretched out on his left side and died quietly a few minutes later. A black moth flew into the room and fluttered against the lamp, while, at the same moment, the cork popped loudly out of the champagne bottle and disappeared through the open window into the darkness.

The final irony transpired with the arrival of Chekhov's coffin in Moscow. It was carried in a green freight car that bore the legend "Oysters" on it. A military band played on the platform, and as the procession began, admirers followed the music. It took some time to realize that they were following the remains of General Keller, who had been killed in Manchuria, and whose coffin had arrived at the station at the same time. The cortege wove its way on foot through the city that Chekhov had so dearly loved. People hanging out their windows to view the coffin as it passed by remind one of the epitaph he wrote in his *Notebooks* many years earlier:

You, you're dead and they're taking you to the cemetery, me, I'm going out to lunch.⁴

(to be continued)

Editorial

MEETING OF THE EXECUTIVE COUNCIL AT MID PINES

September 28, 1975

At its early fall meeting at Mid Pines, September 28, the executive council spent considerable time trying to set the society's course in the professional liability adventure only to have the trail markers switched the next day by St. Paul's abrupt withdrawal from the field. So the contingent plan approved reluctantly at this session to establish a physicians' mutual company had to be activated the next day. While such action is hardly the answer to all the questions raised by all parties to the crisis, it at least represents an attempt to react to the sometimes capricious behavior of other principles in the drama. By the time this report appears, the courts may have resolved some of our problems but many others will remain. Recognizing this, the council elected to "become actively involved by 'amicus curiae' in defending the lawsuits being filed against the reinsurance exchange" and rejected for the present both mandatory and binding arbitration and medical compensation boards as feasible measures in North Carolina. Instead, an ad hoc committee will be established to prepare a statewide campaign to bring about changes in the present tort liability system. Our ad hoc committee on professional liability problems proposed several changes in this system: (1) Community standard of medical care—the bill introduced in the 1975 session of the General Assembly should be reintroduced; (2) Statutes of Limitation—the bill presented in the last session should be reintroduced with a few changes. This bill would have the statute run from the date of occurrence of the action or one year from the date of discovery for foreign object cases, whichever is less. If a minor is 10 years of age or older, this provision would apply; if the minor were less than 10 years old, action could not be brought after his 13th birthday; (3) Informed consent—the 1975 bill should be reintroduced; a provision on statutes of frauds is included; (4) Counter claim law—the model AMA bill should be introduced; (5) Limits on Liability—the general assembly should be asked to establish limits on liability especially because of potential ceilings on purchasable insurance; (6) Collateral source rule—the committee recommended that a bill be drafted which would require revelation in court of all sources of collateral income and that awards should be reduced by the amount of such income; (7) Periodic payment—a bill should be drafted which

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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would require that awards to a plaintiff be paid periodically rather than as a lump sum.

While professional liability problems demanded perhaps the most serious deliberations of the council, other activities were not slighted. Mrs. Charles Herring, its president, brought good news from the auxiliary which should never be suspected of spending most of its time eating open faced sandwiches and sipping sherry. It couldn't with its nearly 2,900 members and its ambitious programs, particularly the student loan fund. The word for Dr. Tilghman Herring's committee on finance was scrupulosity—the utmost exactness—because inflation and the demands for increasing services as well as the unchecked proliferation of paper work should strain any budget, even one greater than a half million dollars. In an effort to increase efficiency of administration, the committee recognized that the society must cope with these increasing demands and accepted a recommendation that computer services be expanded. The recommendations of the council on research and development

were in line with those of the committee on finance: the enunciation of procedures and policy and the codification of administrative activity were urged as was consolidation of committees as ground rules changed.

Post-prandially the council heard reports from the commissions. Although many of the reports might have seemed to the uninitiated to be overly trivial in content, many minor points must be presented to and acted on by the council lest important opportunities be missed and necessary details be lost sight of. After all, the members of the commissions are really the troops in the trenches. For example, relative value scales may now have little import since the Goldfarb case which appears to make lawyers set fee schedules inappropriate, the Medical Peer Review Foundation seeks funds to carry out its properly defined functions if local autonomy is to be preserved and implemented and immediate past-presidents of the society can now go to AMA sessions as expense-paid official members of our delegation if the house of delegates is willing.

Committees and Organizations

MEETING THE LIABILITY ISSUE

In an effort to ease the malpractice insurance crisis when St. Paul Marine and Fire announced it would withdraw from North Carolina, the North Carolina Medical Society House of Delegates met in Raleigh on October 22 to act on the society's proposed mutual liability insurance company. Although John Ingram, commissioner of insurance, announced that day an agreement allowing St. Paul to offer coverage under a modified claims-made plan, the House of Delegates, after unlimited discussion, voted unanimously to proceed with a society-sponsored mutual company. President James Davis reported a management firm was available and the company, already chartered, could be licensed and policies offered within 24 hours.

The House then turned to a long-range resolution under consideration by the Professional Liability Insurance Study Commission of the General Assembly. Dr. Ira Hardy, chairman of the society's ad hoc committee on professional liability insurance and member of the assembly's study commission, presented the following resolution drawn up by the commission in its pursuit of long-range solutions to the malpractice insurance problem.

Resolution of the North Carolina Professional Liability Insurance Study Commission

Whereas, the Professional Liability Insurance Study Commission recognizes that a serious medical

liability insurance crisis exists in North Carolina, and

Whereas, the Study Commission also recognizes that in spite of good medical care, the strong likelihood exists that such a crisis will continue for a long time unless remedial legislation is enacted, and

Whereas, the Study Commission feels that solutions in this crisis should include immediate and long range availability of liability insurance, and

Whereas, the Study Commission feels that there should be more than one source of such insurance in case any carrier withdraws from the market in the future, and

Whereas, the North Carolina Medical Society is presently effecting the formation of a professional liability mutual insurance company, therefore

BE IT RESOLVED THAT:

(1) We shall continue our careful consideration of recommendations for specific legislation concerning the following subjects:

- Statute of limitations
- Limitation of awards
- Informed consent including a statute of fraud
- Standard of care and community rule
- Contingency fees
- Elimination of ad damnum clause
- Counter claims
- Modification of collateral source rule

- Permission to pay awards in periodic payments
- And other suggested changes that have been presented to the commission
- (2) We will recommend that the recommendations of this commission be considered for enactment as

soon as the General Assembly reconvenes.

(3) We strongly urge the North Carolina Medical Society to endorse the formation and operation of the Medical Liability Mutual Insurance Company of North Carolina.

Bulletin Board

NEW MEMBERS of the State Society

Anderson, Carleton Thomas, Jr., MD (Intern-Resident), 33 Beacon Hill Lane, Charlotte

Atkinson, Thomas Temple (STUDENT MEMBER), 1287 Tredwell Dr., Winston-Salem 27103

Austin, Stephen Brawner (STUDENT MEMBER), 1900 Queen St., Apt. C-3, Winston-Salem 27103

Berger, Frederick Allen, MD (PD), 106 Doctors Bldg., Franklin 28714

Browder, James Patterson, III, MD (OTOL), UNC Div. of Otol., Chapel Hill 27514

Burnette, John Eric, Jr., MD (OBG), 3000 New Bern Ave., Raleigh 27610

Chun, Yoon-Taek, MD (Intern-Resident), P. O. Box 68, Broughton Hospital, Morganton 28655

Czermak, Charles Louis, Jr., MD (R), Rt. 3, Box 20-J, Boone 28607

Guiteras, Patrick, MD, Hayes Bldg., Glen Lennox Station, Chapel Hill 27514

Henry, Francis Patrick, MD (EM), Margaret Pardee Mem. Hospital, Hendersonville 28739

Homesley, Howard David, MD (GYN), Bowman Gray, Winston-Salem 27103

Hooper, Lawrence Hoskins, Jr. (STUDENT MEMBER), 310 Umstead Dr., Chapel Hill 27514

Hucks-Follis, Anthony George, MD (NS), P. O. Box 2000, Pinehurst 28374

Johnson, Trent Andrew, MD (R), Angel Comm. Hospital, Franklin 28734

Kinnard, Richard Edward (STUDENT MEMBER), 12-C Sharon Heights, Chapel Hill 27514

Laurens, John, MD (PR), 706-A Fleming St., Hendersonville 28739

Lawson, Paul Steven, MD (R), Rt. 66, Box 20-L, Cullowhee 28723

MacDonald, Henry John, Jr., MD (Intern-Resident), 122 Taylor St., Chapel Hill 27514

Manning, Richard Oliver, MD (OBG), 703 Tilghman Dr., Dunn 28334

Martin, Wayne Robert, MD (FP), Garrett Mem. Hospital, Crossnore 28616

Meadors, Walter Vernon, Jr. (STUDENT MEMBER), 717-J Poplar St., Carrboro 27510

Newton, Douglas Frisbie, MD (IM), 1705 W. Sixth St., Greenville 27834

Peters, Calvin Ronald, MD (PS), Duke Med. Ctr., Div. Plastic Surgery, Durham 27710

Powell, Robert Narroway, MD (Intern-Resident), Box 236, N. C. Baptist Hospital, Winston-Salem 27103

Schulhof, Larry Alan, MD (NS), 311 Doctors Bldg., Asheville 28801

Schumacher, Donald, MD (IM), 1008 Braeburn Rd., Charlotte 28207

Seltzer, Stephen Charles, MD (Intern-Resident), 1200 N. Elm St., Greensboro 27401

Singer, Francis Phillip Graham, MD (Intern-Resident), 104 W. Lavender St., Durham 27704

Sink, James David, MD (Intern-Resident), 4205 Sunny Ct., Durham 27705

Sloan, Anita Diane (STUDENT MEMBER), 8-E Yum Yum Apts., Carrboro 27510

Smith, Jeffrey Alan (STUDENT MEMBER), 410 E. Bass Court, Cary 27511

Stewart, William Lee (STUDENT MEMBER), 125 Craig Hall, UNC, Chapel Hill 27514

Thompson, William Moreau, MD (R), 3920 Hope Valley Rd., Durham 27707

Warshauer, Albert David, MD (AN), Renewal, Apt. #2, 401 Meade St., Greenville 27834

Weeks, Duke Byron, MD (AN), 2615 Telwood Court, Winston-Salem 27103

White, Mack Willis, III (STUDENT MEMBER), 821 Old Pittsboro Rd., Chapel Hill 27514

Wille, Carl Richard, MD (OPH), 204 Martinsborough Rd., Greenville 27834

Williams, Dixon Caldwell (STUDENT MEMBER), 4216 Garrett Rd., Apt. B-30, Durham 27707

WHAT? WHEN? WHERE? In Continuing Education

December 1975

Note: (1) Programs sponsored by the Bowman Gray, Duke or UNC Schools of Medicine are approved for "Category 1" AMA Physician Recognition Award credit, and for AAFP "Prescribed" continuing education credit when such approval has been granted by the AAFP. (2) "Place" and "sponsor" are indicated below only where these differ from the place and group or institution listed under "For information."

PROGRAMS IN NORTH CAROLINA

December 26, 1975-January 9, 1976

First American-German Postgraduate Medical Congress
Place: Holiday Inn, Nassau

Program: Fifteen qualified University Professors from the United States and Germany, all bi-lingual, will participate in teaching seminars recommended for practicing physicians, internists, cardiologists, & family physicians. The program will be followed by a Caribbean cruise

For Information: S. Heyden, M.D., Department of Community Health Sciences, Duke University Medical Center, Durham 27710

January 15-17

Epilepsy for Pediatricians

Fee: American Academy of Pediatrics members \$100; non-members \$135

For Information: John F. Griffith, M.D., Box 2975, Duke University Medical Center, Durham 27710

January 22-24

Sixth Annual Surgical Symposium: Management of the Acutely Injured Patient

Fee: \$135

Credit: 15 hours: AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Con-

tinuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

January 28-30

Alcoholism—The Search for the Sources
Place: Downtowner East Motor Inn, Charlotte
Sponsors: North Carolina Medical Society, Charlotte Area Health Education Center, "and others"

Program: The program will focus primarily upon research into the origins of alcoholism. Clinically oriented presentations are included

Fee: \$15

Credit: 16½ hours; AMA Category I; AAFP approved

For Information: John A. Ewing, M.D., Director, Center for Alcohol Studies, University of North Carolina, Chapel Hill 27514

January 30-31

Conference for Medical Leadership

Place: Royal Villa Hotel, Raleigh

Program: Workshop topics will include: The AMA; County Society Administration; Health Systems Agency; and The North Carolina Peer Review Foundation Activities

For Information: William N. Hilliard, Executive Director, North Carolina Medical Society, Box 27167, Raleigh 27611

February 7-8

Endoscopy Workshop (re-scheduled from December 6-7, 1975)

Place: Berryhill Hall

Sponsors: Department of Medicine and the Office of Continuing Education, UNC School of Medicine

Fee: \$75; enrollment limited to 100

Credit: AAFP credit applied for

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

February 11

Wingate M. Johnson Memorial Lecture

Place and time: Babcock Auditorium, 11:00 A.M.

Speaker: Dr. Grant Liddle, Professor and Chairman, Department of Medicine, Vanderbilt University School of Medicine

Credit: 2 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

February 21-22

Clinical Application of Biochemical Determination in Drug Treatment of Affective Disorders

For Information: Joseph Parker, M.D., Department of Psychiatry, Box 3837, Duke University Medical Center, Durham 27710

February 23-27

The Management of Craniofacial Pain

Sponsors: UNC School of Dentistry, School of Medicine, Dental Research Center and School of Nursing. Presented by UNC Pain Clinic

Fee: \$200; enrollment limited to 80 participants

Credit: 29 hours; AAFP credit applied for

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 5-6

General Diagnostic Radiology Updated

Fee: \$100

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 19-20

E. C. Hamblen Symposium in Reproductive Biology and Family Planning

For Information: Charles B. Hammond, M.D., Box 3143, Duke University Medical Center, Durham 27710

March 22-26

Radiology of the Urinary Tract—a Tutorial Postgraduate Course
Program: Emphasis on personalized small group tutorial type teaching. Subject matter will cover all facets of urinary tract disease, including comprehensive coverage of diagnostic techniques

Fee: \$300

Credit: 30 hours

For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

March 25-26

Medical Alumni Day and Scientific Meetings

Place: Berryhill Hall

Sponsor: Office of Continuing Education and Alumni Affairs

Credit: To be announced

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

March 26

Symposium on Alcoholism

Fee: \$25

Credit: 6 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

March 29-30

Obstetrics and Gynecology Postgraduate Course

Fee: \$35

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 9-10

Practical Pediatrics

Fee: \$35

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 9-10

(Note change of date)

Annual Arthritis Symposium

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 16-17

Practical Nuclear Medicine: Emphasis Oncology

Fee: \$75

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 22

New Bern Annual Medical Symposium—1976, "Pulmonary Medicine"

Place: Ramada Inn, New Bern

Sponsor: Craven—Pamlico—Jones County Medical Society

Credit: 5 hours; AAFP credit applied for

For Information: Zack J. Waters, M.D., Box 1089, New Bern 28560

April 23-24

Perinatology Post-Graduate Course

For Information: Oscar L. Sapp, III, M.D., Associate Dean for Continuing Education, UNC School of Medicine, Chapel Hill 27514

April 23-30

Medical Symposium—Cruise to Bermuda

Sponsors: Bowman Gray School of Medicine and the Medical University of South Carolina

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

April 30-May 1

(Note change in date)

Diving Deafness and Related Physiology

Fee: \$35

Credit: 9 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 6-9

122nd Annual Session of the North Carolina Medical Society

Place: Pinehurst Hotel and Country Club, Pinehurst

For Information: William N. Hilliard, Executive Director, North Carolina Medical Society, Box 27167, Raleigh 27611

May 12-13

Breath of Spring '76: Respiratory Care Symposium

Fee: \$25

Credit: 12 hours; AAFP credit applied for

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

May 27-28

The 27th Scientific Sessions of the North Carolina Heart Association

Place: Benton Convention Center and the Winston-Salem Hyatt House, Winston-Salem

Sponsors: The North Carolina Chapter of the American College of Cardiology will be one of the co-sponsors of the sessions, and will hold its sessions, which are open to all physicians, on May 28. Special concurrent sessions will be held for nurses, emergency medical technicians, and cardiology technologists

For Information: Thomas R. Griggs, M.D., North Carolina Heart Association, P.O. Box 2408, Chapel Hill 27514

ITEMS OF SPECIAL INTEREST

The 1975 *Revised North Carolina Dietetic Association's Diet Manual* as well as revised diet pages for those who already have the manual are now available. The cost of the manual is \$10.40; the packet of revised pages is \$2.60.

For Information or to order: Karen C. Hauersperger, NCDA Executive Secretary, 5836 Gate Post Road, Charlotte 28211

Hypertension Seminars for Dentists

The North Carolina Regional Medical Program, the North Carolina Heart Association, the North Carolina Medical Society and the UNC School of Dentistry are cosponsoring a series of hypertension seminars to be held throughout the state of North Carolina. Dates and places of the remaining seminars are as follows:

January 17Chapel Hill
February 7Charlotte
February 28Greenville
March 20Wilmington

For Information: North Carolina Heart Association, P.O. Box 2408, Chapel Hill 27514

University of Maryland CME

The Program of Continuing Education of the University of Maryland School of Medicine has a broad range of two and three day CME courses available to interested physicians. The schedule through the 1975-1976 academic year includes such topics as neuropathology, dermatology, gastroenterology, blood diseases, pulmonary conditions, psychiatry for the family physician, internal medicine, sexual abuse, obstetrics, child development, drug abuse and a family practice review course.

For Information: Steven L. Barber, Educational Coordinator, Program of Continuing Education, University of Maryland School of Medicine, 29 South Greene Street, Baltimore, Maryland 21201

PROGRAMS IN CONTIGUOUS STATES

January 31

Workshop on Infectious Diseases and Antimicrobial Therapy

For Information: Doris Croley, Education Director, Oak Ridge Hospital of the United Methodist Church, Oak Ridge, Tennessee 37830

February 5-6

Symposium on Recent Advances in Bacterial & Viral Gastroenteritis

Sponsors: Department of Continuing Education and the Department of Microbiology

Fee: \$50

Credit: 12½ hours; AMA Category 1; AAFP credit applied for

For Information: Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, Richmond, Virginia 23298

May 10-13

The Frontiers in Cardiology

Place: Royal Coach Motor Hotel, Atlanta, Georgia

Sponsors: Council on Clinical Cardiology, American Heart Association; Department of Medicine, Emory University School of Medicine in cooperation with the Georgia Heart Association

Fee: ACC members \$125; non-members \$175

Credit: AMA Category 1

For Information: Miss Mary Anne McNerny, Director, Depart-

ment of Continuing Education Programs, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014

Medical College of Virginia

The number in parenthesis, following the title, indicates the number of hours for that particular course.

January 8 Pediatric Allergy and Immunology for the Practicing Physician (4)

January 19-22 The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (40)

January 29 Adolescent Medicine for Practicing Physicians (4)

January 29 Medico-Legal Workshop (5). Held at Tidewater Memorial Hospital, Tappahannock, Virginia.

February 5-6 Symposium on Recent Advances in Bacterial and Viral Gastroenteritis (12½)

February 18 Pediatric Hematology—Oncology for the Practicing Physician (4)

February 29- March 4 Radiology of the G. U. Tract (24). This program will be held in Williamsburg, Virginia

March 18 Neonatology for the Practicing Physician (4)

March 25-26 29th Annual Stoneburner Lecture Series—Neurology for Primary Care Physicians (12)

April 1 Pediatric Cardiology for the Practicing Physician (4)

April 22 Medico-Legal Workshop (5). Held at Virginia Baptist Hospital, Lynchburg, Virginia

May 17-18 EEG Symposium (14)

May 21 Annual Spring Forum for Child Psychiatry (4)

June 2 Pediatric Nephrology for Practicing Physicians (4)

For further information on the above CME offerings, write to the Department of Continuing Education, School of Medicine, Medical College of Virginia, Box 91, Richmond, Virginia 23298

Items submitted for listing should be sent to: WHAT? WHEN? WHERE?, P.O. Box 15249, Durham, N.C., 27704, by the 10th of the month prior to the month in which they are to appear.

News Notes from the—

BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dr. Giles L. Cloninger, a Hamlet physician, has been installed as the 21st president of the Bowman Gray Medical Alumni Association. He succeeds Dr. Ernest H. Stines, Jr. of Canton.

Dr. Wayne A. Cline of Salisbury has been elected president-elect. The elections came during the association's annual meeting.

Miss Katherine Davis, assistant to the director of the Bowman Gray-Baptist Hospital Medical Center, was re-elected secretary.

Elected to four-year terms on the association's alumni council were Dr. Joseph A. Fleetwood, Jr. of Conway; Dr. H. Wesley Garbee of Asheville; Dr. Benjamin E. Morgan of Rocky Mount; Dr. Dixie L. B. Soo of Lima, Ohio; Dr. O. Richard Thompson of Lenoir and Dr. Larry A. Tyree of Raleigh.

During the alumni banquet, four distinguished alumni lecturers received certificates. They went to Dr. F. Murray Carroll of Chadbourn; Dr. Frederick Glass, assistant professor of surgery and acting head of Bowman Gray's Section on Emergency Medical Services; Dr. J. Kiffin Penry, chief of the Applied

Neurologic Research Branch of the National Institute of Neurological and Communicative Disorders and Stroke; and Dr. Douglas H. Sandberg, professor of pediatrics and co-director of the Clinical Research Center of the University of Miami School of Medicine.

* * *

The Bowman Gray School of Medicine has been given a first edition of "Opticks," written by Sir Issac Newton and published in 1704.

The book, one of Newton's most influential works, is subtitled "A Treatise of the Reflexions, Refractions, Inflexions and Colours of Light."

Dr. R. Winston Roberts, who recently retired after 27 years as head of Bowman Gray's Section on Ophthalmology, presented the book to the school.

Through a donation from the alumni fund of the class of 1968, the school has purchased a collection of 22 volumes written by and about Drs. John and William Hunter, Scottish anatomists of the 18th century.

Dr. Frank R. Lock, who created Bowman Gray's Department of Obstetrics and Gynecology and served as its chairman for 25 years, also has presented the school with his copy of "Essai Sur L'Abus des Regles et Contre Les Prejuges qui S'Opposent au Progress de L'Art Des Accouchemens" by Andre Levret. The book was published in 1766.

As a companion to the Levret work, the school has purchased another Levret book, "Observations Sur Les Causes et Les Accidens de Plusieurs Accouchemens Laborieux," published in 1770.

* * *

Dr. Donald H. Hayes, associate dean for community health sciences and professor and chairman of the Department of Community medicine, served as chairman of a three-day October workshop on "Cancer Control and School Health Education" in Denver, Colo.

The purpose of the meeting was to determine the level of school health education programs nationwide and their efforts which relate to cancer control, and to gather recommendations for developing school health programs which further cancer prevention, screening and early diagnosis.

The meeting was sponsored by the Division of Cancer Control and Rehabilitation of the National Cancer Institute.

* * *

An exhibit entered by the Section of Urology was awarded first prize at the American Institute of Ultrasound in Medicine meeting in Winston-Salem in October. The exhibit was prepared by James W. Willard, research assistant professor in urology and was entitled "Gray Scale Technique of Pelvic Organ Ultrasonography."

* * *

Dr. Richard B. Marshall has been appointed professor of pathology and director of anatomical pathology

at Bowman Gray. Dr. Marshall comes to the medical school from the University of Texas Medical Branch at Galveston, where he was professor of pathology and director of surgical pathology and cytopathology.

* * *

North Carolina Baptist Hospital, Bowman Gray's principal teaching hospital, has opened its Ambulatory Care Building.

The building is the new home for the emergency medicine department, the cast room, the Department of Orthopedics, the radiation therapy section, the cancer research center, the physical therapy department and the majority of outpatient clinics.

The building is adjacent to the 16-story Reynolds Tower.

* * *

Dr. James A. Chappell, associate professor of community medicine, has been reappointed to a three-year term as a member of the Forsyth-Stokes Area Mental Health Board.

* * *

Dr. William D. Wagner, assistant professor of community medicine, has been appointed to a four-year term on the Research Review Sub-Committee of the Medical and Community Program Committee of the North Carolina Heart Association.

News Notes from the—

UNIVERSITY OF NORTH CAROLINA DIVISION OF HEALTH AFFAIRS

Three new divisions chiefs have been appointed in the department of medical allied health professions at the UNC School of Medicine at Chapel Hill.

Dr. Ruth U. Mitchell will direct the division of physical therapy, Dr. Robert Sakata will head the division of rehabilitation counseling, and Dr. Joanne K. Stephan will be in charge of the division of medical technology.

* * *

Community health specialist Dr. Kurt W. Deuschle delivered the UNC School of Medicine's 1975 Merrimon Lecture on Wednesday, Oct. 15. His topic was "Urban Health and Academic Medicine: Changing Responsibilities of Medical Schools in Big Cities."

Endowed by the late Dr. Louise Merrimon Perry in memory of her father, the lectureship brings a distinguished speaker to Chapel Hill each fall. Dr. Deuschle, the eighth Merrimon lecturer, is the Ethel H. Wise Professor of Community Medicine at the Mt. Sinai School of Medicine in New York.

* * *

Dr. Charles R. O'Melia, professor of environmental sciences and engineering in the School of Public

Health at the UNC-Chapel Hill, has been named associate editor of *Environmental Science and Technology*, a monthly publication of the American Chemical Society.

Dr. O'Melia is serving under the editorship of Dr. Russell Christman, chairman of the UNC department of environmental science and engineering.

* * *

L. Irene Hollis, director of occupational therapy at the Hand Rehabilitation Center at the UNC at Chapel Hill, attended the annual conference of the American Occupational Therapy Association in Milwaukee, Wisconsin. She presented papers on "Pre- and Post-Operative Therapy for Tendon Transfers," "Sensory Re-education" and "Simplified Hand Splinting."

* * *

New Faculty, UNC School of Medicine:

Bernard E. Statland, associate professor, department of pathology, and associate director, clinical chemistry laboratory, department of hospital laboratories, has been assistant professor at the University

of Minnesota where he received his B.A., M.D. and Ph.D.

Joanne K. Stephan, associate professor, department of medical allied professions, also is appointed program director, medical technology program, and director of education, medical technology, department of hospital laboratories. A graduate of St. Mary-of-the-Woods College she received her medical technology certificate at Norton Memorial Infirmary, Kentucky, M.S. from the University of Louisville School of Medicine, and Sc.D. from Johns Hopkins University. Prior to joining the UNC faculty, she was assistant professor of medical technology and pathology at the Medical College of Virginia.

Steven L. Bachenheimer, assistant professor, department of bacteriology and immunology, received his B.S. from the University of Illinois and his Ph.D. from the University of Chicago. From 1972-74 he was a Damon Runyan Memorial Fund Postdoctoral Fellow.

Margaret B. Dillard, assistant professor, department of radiology, has been a computer programmer at N.C. Memorial Hospital in Chapel Hill since 1973.



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A graduate of Mt. Holyoke College, she earned her Ph.D. from UNC.

Peter Stevens, assistant professor, department of surgery, spent 1974-75 in England as a registrar in pediatric surgery at Queen Mary's Hospital for Children in Surrey. He also worked with Mr. D. Innes Williams, consultant urologist at Great Ormond Street Hospital for Sick Children in London. He holds the M.D. from Emory University.

Promotion:

Barry P. Hickey, department of medicine, was promoted to assistant professor.

* * *

Dr. Floyd Denny, chairman of the department of pediatrics, UNC School of Medicine at Chapel Hill, was a visiting professor at the Royal College of Physicians in Dublin, Ireland during the month of October. While in Dublin, he delivered a lecture on *Mycoplasma pneumoniae*, an organism that causes numerous respiratory diseases.

News Notes from the—

DUKE UNIVERSITY MEDICAL CENTER

Dr. Johnnie L. Gallemore, Jr., a medical center physician-lawyer who is currently working in Washington helping the U.S. House of Representatives draft health legislation, has been named honorary minister of the year by the Lavin J. Burcham Evangelistic Association of Greensboro.

According to the Rev. Mrs. Kathy Brooks of the organization, Gallemore was cited for "his outstanding work for the people of North Carolina."

* * *

Over the past several years, a Duke surgeon has been developing a surgical technique to reconstruct breasts in patients who have had to undergo mastectomies.

The surgeon, Dr. Nicholas Georgiade, has now received an award of \$80,000 from an anonymous donor to support his clinical research in this field of reconstructive surgery.

Georgiade, who is chief of the Division of Plastic Surgery, also has written a book on the subject, "Reconstructive Surgery of the Breast," to be published in the coming year.

Georgiade said that the artificial breast, or prosthesis, he has developed looks and feels like a normal breast. It is covered with soft plastic and is filled with a sterile syringe gel.

"The prosthesis makes it unnecessary for a patient to have an artificial breast built into her brassiere," Georgiade said. "This provides a psychological advantage to the woman," he explained, "because the prosthesis becomes a part of the patient."

The Division of Dermatology in the Department of Medicine has a new chief, Dr. Gerald Sylvan Lazarus.

Lazarus succeeds Dr. J. Lamar Callaway, whose relationship with Duke spans 45 years, 38 of them as head of dermatology. Callaway is James B. Duke Professor of Dermatology and he will continue his activities in patient care, teaching and research.

The new division chief was head of the Section of Dermatology at Montefiore Hospital and Medical Center in New York City. He also was associate professor of medicine and co-director of the Training Program in Dermatology at the Albert Einstein College of Medicine.

A native of New York, Lazarus received a B.S. degree in chemistry at Colby College in Waterville, Me., in 1959, and his M.D. in 1963 at the George Washington University School of Medicine.

He served a medical internship and residency at the University of Michigan Medical Center and was chief resident in dermatology at Harvard. He has held clinical and research positions at Harvard and at the National Institutes of Health, and from 1970-72 he was visiting scientist and consultant in dermatology in Cambridge, England.

Lazarus, who holds the rank of professor here, had been at Montefiore and Einstein since 1972.

Callaway's relationship with Duke dates almost from the medical center's beginning. He holds B.S. degrees in medicine from both Duke and the University of Alabama, and he received his M.D. degree here as a member of the class of 1933.

He served his internship and residency here and then worked briefly as an instructor in the schools of medicine at the universities of Alabama and Pennsylvania before joining the Duke faculty in 1937.

* * *

Nineteen Duke doctors took part in the American College of Surgeons Clinical Congress in San Francisco.

Solo participants were:

Dr. Robert W. Anderson, who spoke on "Post-operative Problems in Respiratory Management."

Dr. James F. Glenn, a panelist in the discussion of "The Management of Renal Mass Lesions."

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Dr. David F. Paulson, a panelist discussing "Immunotherapy in the Treatment of Genitourinary Malignancies,"

Dr. Samuel A. Wells, Jr., who covered "Diagnosis and Treatment of Islet Cell Tumors of the Pancreas,"

Dr. Walter G. Wolfe, who spoke on "Pulmonary Embolism: Recognition and Management," and

Dr. David C. Sabiston, Jr. who presided at the keynote speech and who introduced the speaker, Dr. James V. Maloney, Jr.

Five groups of Duke researchers presented papers. The topics and authors were:

"Augmentation of Coronary Collateral Blood Flow in Acute Myocardial Infarction"—Dr. Jimmy L. Cox, Dr. Harvey I. Pass, Dr. Robert W. Anderson, Dr. Andrew S. Wechsler, Dr. H. Newland Oldham, Jr., and Dr. David C. Sabiston, Jr.

"Spasticity: Actions of Selectively Activated Group II Muscle Spindle Afferents on Extensor Motoneurons"—Dr. Charles C. Duncan, Dr. David S. Zorub and Dr. Wesley A. Cook, Jr.

"Physiologic and Pathologic Responses of the Pulmonary Circulation to High Flow Shunts"—Dr. William C. DeVries and Dr. Robert W. Anderson.

"Immunologic Enhancement in a Syngeneic Tumor System"—Dr. William R. Beltz and Dr. Nelson L. Levy.

"Cross-reactions between Virally and Chemically Induced Mouse Sarcomas: Surface Expression on a Common Viral Antigen"—Dr. John P. Grant, Mary S. Curtas, Dr. Dani P. Bolognesi, and Dr. Samuel A. Wells, Jr.

* * *

The following appointments and promotions have been made at the Medical Center:

Appointments

Drs. Frederick M. Kelvin, Saluterio Martinez and William S. Trought, assistant professors of radiology.

Drs. Guy C. Davis, Jr., James F. Mayhew and John N. Miller, assistant professors of anesthesiology.

Drs. James B. Bobula, Jesse D. Samuels and William E. Wilkerson, assistant professors of community health sciences.

Dr. Frederick R. Jelovsek, assistant professor of obstetrics-gynecology.

Dr. Keith A. Reimer, assistant professor of pathology.

Promotions

Dr. James T. T. Chen, to professor of radiology.

Drs. Patrick A. McKee, Harold R. Silberman and John P. Tindall, to professors of medicine.

PHYSICIANS CAN HELP CHOOSE GOOD DAY CARE

As the number of working mothers in North Carolina increases, many parents have no alternative to placing their children in day care programs. The significance of the developmental years makes the

choice of a day care center a vital decision for parents of preschoolers. Parents often rely on their physicians, particularly their pediatricians, for advice in making such a choice. For a physician to give advice about day care, he must know the major requirements for licensing as well as what constitutes quality day care.

Any day care arrangement with more than six children must be licensed annually by the state. To receive a license a center must meet minimum standards of the General Statutes administered through the Office of Child Day Care Licensing and must comply with state sanitation, building and fire codes. Personnel must be in good physical and mental health and are required to have annual medical checkups. The center must adhere to state licensing regulations regarding immunizations, first aid and caring for ill children. Each child placed in a licensed center must have a physical examination before enrollment or within two weeks thereafter and each is required to have up-to-date immunizations. Day care administrators are required to keep medical records on all children enrolled.

The center must have an emergency care plan, which includes the services of a medical consultant. The administrator must also have the name, address and phone number of each child's physician, the preferred hospital and names of persons to call when emergencies occur. At least one staff member must know first aid and be able to recognize symptoms of common diseases.

All medications, cleaning supplies, insecticides and such must be stored in locked compartments. No medication may be given a child unless prescribed for that child by a physician or by consent of the child's parents.

Nutritious meals and snacks must be served. A good lunch would include a meat, vegetables, bread, butter, milk and fruit or pudding. Snacks must be served each morning and afternoon.

All centers must provide rest periods after lunch or at some other appropriate time. Each child must have an individual cot or mat and clean linens.

Day care centers must provide for outdoor play each day the weather permits. The outdoor play area must be fenced, free of hazards and total 75 square feet per child. The center must also have indoor play space amounting to 25 square feet per child.

A center must have fire extinguishers, a posted fire evacuation plan and monthly fire drills.

In addition to these major requirements for licensing, a quality day care program will include:

- Periodic medical and dental checkups;
- A staff alert to early signs of visual, hearing and speech defects;
- Bright, cheerful rooms;
- Understanding personnel;
- Toys and equipment in good repair;
- A program which stimulates learning;
- Parent participation in the facility's activities;
- Community involvement.

A quality day care program offers a child healthy social and educational experiences under supervision in a safe and stimulating environment. The physician who is aware of quality day care will be in a better

position to advise working parents.

For more information concerning day care, write the North Carolina Office of Child Day Care Licensing, P. O. Box 10157, Raleigh, North Carolina 27605.

Month in Washington

The American Medical Association brought the concerns of American medicine to the attention of the Congress a number of times during the season of the Harvest Moon.

At a hearing before a House Judiciary Subcommittee looking into the charge that federal agencies may be taking too much power into their own hands, the AMA testified that "although potentially inherent in many agencies, abuses have become more obvious in the health agencies during the past 10 years."

Raymond T. Holden, MD, Chairman of the AMA Board of Trustees, said the many health programs Congress approved during this time "because of the complexity of the solutions inherent, were often mere skeletons. In its haste to provide operational programs, Congress often has allowed executive agencies and bureaus to add the flesh."

As a result, Dr. Holden said, the final program often is "unrecognizable" from what Congress had in mind. He charged there has been intentional non-conformance with Congress' intent, "an insatiable appetite for more regulation" in which the bureaucracy "runs amok by attempting to regulate any activity which touches upon, influences, or is affected by the Congressional program." The time is long overdue to put a stop to regulatory abuse, the AMA official told the Subcommittee.

Dr. Holden pointed to the Health, Education and Welfare Department's actions on Utilization Review. After withdrawing the initial proposal for hospital pre-admission certification, strongly opposed by the AMA, the Department went ahead with final rules that were "equally objectionable" in requiring review of all patients within 24 hours. Dr. Holden said provisions of the basic Medicare law were "improperly invoked" and irrelevant provisions of other programs were "imperiously used" by HEW. The AMA brought suit and was successful in obtaining a preliminary injunction upheld on appeal.

Edgar T. Beddingfield, MD, Vice Chairman of the AMA's Council on Legislation, told the Subcommittee the AMA is backing a measure to amend the Administrative Procedures Act to require agencies to follow certain procedures. The bill, introduced by Rep. Thomas Kindness (R-Ohio), calls for adequate

time for comment, and expands the type of governmental actions that would come under the rulemaking regulations. The bill (H.R. 10301) requires the agency to include "the rationale in accepting, rejecting, or accepting in modified form the comments received by the interested parties." Dr. Beddingfield said this is to "assure that the agency not indulge further in its practice, often utilized, of rejecting out-of-hand comments with which it does not agree . . ." Any final rule substantially changed from its proposed form would have to go through the process as a proposed rule to allow comment, he said.

* * *

The AMA told Congress it is time to improve the health of Indians.

"The Association believes that today, when the nation appears ready to correct some of the wrongs done the first Americans, there is an opportunity to bring the health status of the American and Alaskan Native to the level of the general population, rather than remaining decades behind."

Robert B. Hunter, MD, a member of the AMA Board of Trustees, said the Indian Health Service "has done well with what it has, but it does not have enough." Dr. Hunter, testifying before the House Subcommittee on Indian Affairs, endorsed legislation before the House and Senate to improve health services for Indians.

In the past, increases in the budget for Indian health services have done little more than keep up with inflation, the physician told the lawmakers. "They have enabled the Service to maintain its health care system, but not to improve it." Only a few new facilities have been built or old ones modernized, Dr. Hunter noted.

Based on extensive studies by the AMA and others, Dr. Hunter said, one solution to the manpower needs must be to attract more Indians to the health professions. He supported provisions in the measures to train more Indian physicians through scholarships and in other ways.

Changes were recommended to allow employment of private health professionals on a contract basis to meet backlogs in health care services needed by Indians. An immediate construction and modernization

program for health facilities was endorsed as well as provisions requiring Indian participation in planning and program operation.

He urged passage of a provision for a one-year study to investigate alcoholism and mental health among Indians.

* * *

Bills before Congress to impose additional regulations on lobbying activities were opposed by the AMA as "unnecessary and discriminatory."

The goal of the legislative proposals for "open government" could be defeated by the reform plans which could stifle legitimate and needed contacts of citizens and their organizations with the Government, Executive and Congress, the AMA said.

In a statement for the House Judiciary Subcommittee considering the issue, the AMA noted the multitude of federal health programs that involve communications by physicians and their organizations with the Government. "This access is necessary in the future to assure the maximum input of the expertise and experience of the physician and of his practical concern for the individual beneficiary," the AMA said. "This input must not be subject to unnecessary regulation."

One upshot of the legislation would be to bring under federal controls great numbers of organizations and people who heretofore have not been considered

lobbyists, including state and local medical organizations.

A provision of a major lobbying bill could control organizations with periodic publications which report on legislative and regulatory affairs, the AMA said. Such organizations would have the alternative of complying with the reporting and other burdens imposed by the bill, or to cease reporting on regulatory and legislative affairs of legitimate interest to members, according to the AMA statement.

Another provision could require the reporting of all members of organizations who contribute more than \$100 during a year, possibly including dues. "Such a requirement would be extremely onerous and in many situations compliance would be impossible," said the AMA. "These provisions of the bill would be harsh and unfair and could serve little or no purpose except harassment."

In discouraging communications with Congress, the goal of open government would be defeated, the statement declared.

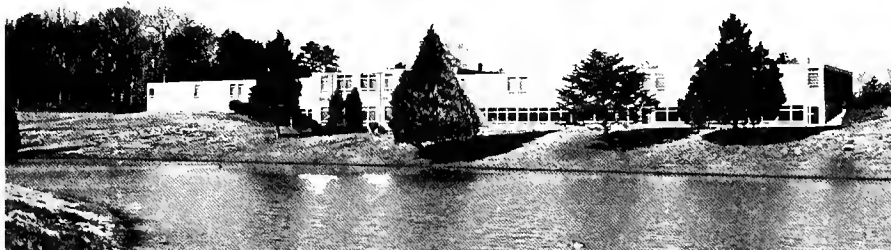
* * *

A resolution backed by the AMA has been introduced in Congress to authorize the President to designate the week of April 4, 1976, as National Rural Health Week. The resolution, aimed at spurring Congressional and public interest in rural health problems, was introduced in the House by Rep. Ed Jones (D-

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Tenn.) and eight co-sponsors. A resolution is slated to be introduced in the Senate soon. Other House sponsors were Reps. Bob Bergland, (D-Minn.), John Breckinridge, (D-Tenn.), Tim Lee Carter, MD, (R-Ky.), Allan Howe, (D-Utah), James Jeffords, (R-Vt.), Matthew McHugh, (D-N.Y.), Gunn McKay, (D-Utah), and Don Young, (R-Alaska).

* * *

The American Medical Political Action Committee has asked the Federal Election Commission to permit political groups to solicit support or endorsement of federal candidates through communications with members without having to subject such expenditures to the disclosure requirements of the law.

Rex Kenyon, MD, a member of the AMPAC Board of Directors, told the Commission the Elections Law approved by Congress provides that contributions or expenditures "shall not include communications by a corporation to its stockholders and their families or by a labor organization to its members and their family on any subject." Another section provides that expenditure does not include "any communication by a membership organization . . . to its members. . . ."

However, Dr. Kenyon said, the Elections Commission would appear to limit the directive of Congress allowing communications on any subject to prohibit the endorsement or solicitation of support for a federal candidate or office-holder. "We believe this is unwise," he said.

Stressing that AMPAC "has no objection whatever to the full disclosure of any and all of its activities," Dr. Kenyon said AMPAC would like to assure its members "that they can participate openly and freely without fear of being in violation of unduly restrictive laws and regulations."

* * *

Quick action has been urged by the House Health Subcommittee staff to block rollbacks in Medicare reimbursement rates for physicians during the current fiscal year.

Charging that the HEW Department's index for calculating reimbursement has had the "unintended and unanticipated effect" of pushing some current payment levels below those of last year, the staff said in a report that Congress will have to move quickly "in order to make it as administratively feasible as possible to modify the current situation."

The Subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), voted tentative agreement on amending the index "so as to preclude any rollback of fiscal year 1976 prevailing fees below fiscal year 1975 prevailing fees."

The change was one of the major goals sought by the AMA in testimony before the Subcommittee last month. The administration had acknowledged the problem, but refused to support legislation to correct it, merely noting that the rollback problem would not reoccur in future updates of prevailing charge screens.

In a staff document, the Ways and Means Subcom-

mittee noted that the economic index for physicians' fees was not issued by HEW until last April, almost two and a half years since the enabling legislation was passed. Only 30 days were then allowed for comment from interested parties, a time squeeze that generated such criticism that the regulations were the subject of hearings by the Subcommittee June 12 and then last month.

"It should be pointed out that if HEW had not delayed so long in implementing the regulations, there would not have been any rollbacks in prevailing charges," the report said.

One of the major criticisms levelled at the rollback by the staff was the effect on physician acceptance of assignment under Medicare.

"It is predictable that the rollbacks will further discourage physicians from accepting assignment" and "result in an even further decrease in the assignment rate with the consequence that beneficiaries will pay an even larger proportion of their medical bills out-of-pocket," said the report.

To illustrate how the rollback operates, the report said a beneficiary or a physician who was paid \$20 for an office visit in fiscal year 1975 may get only \$18 in the current fiscal year 1976.

Beyond the rollback question, the staff pointed out that members of the medical profession (including the AMA) "expressed great concern over the individual indices used to make up the overall index" which was designed to gear Medicare reimbursement with rising costs of living in general. Critics contended that the indices "did not fairly represent their increases in practice expenses. In particular, the index does not allow for the increases in malpractice insurance premiums physicians have experienced."

Edgar T. Beddingfield, MD, Vice Chairman of the AMA's Council on Legislation told the Subcommittee last month that the physician's fee index developed by HEW was an "abuse of the regulatory process." Dr. Beddingfield urged that the economic index be repealed.

* * *

A catastrophic-oriented national health insurance plan has been introduced into the Senate by Russell Long (D-La.) and Abraham Ribicoff (D-Conn.).

The bill, much the same as last year's version, was co-sponsored by 11 other Senators including Senate Majority Leader Mike Mansfield (D-Mont.), Senate GOP Leader Hugh Scott of Pennsylvania, and Senator Herman Talmadge (D-Ga.), Chairman of the Finance Subcommittee on Health.

The Long-Ribicoff bill has been the dark horse challenger in the NHI picture, opposed by all of the major outside groups offering NHI programs. It is especially repugnant to labor, and has been fought by the Administration. As the bi-partisan list of Long-Ribicoff sponsors indicates, however, the measure has a lot going for it in the Senate where it ranks with organized labor's Health Security Act championed by Sen. Edward Kennedy (D-Mass.) as a contender.

Long waited a long time to put in his bill this year, prompting speculation he figured NHI was a dead issue or that he had changed his mind about his bill. As it turned out, Long chose an introduction time when interest appeared to be reviving on Capitol Hill for a catastrophic approach to NHI.

Cost of the bill was put at \$7 billion yearly.

The Administration held off submission of an NHI plan this year, but is almost sure to offer a plan next year similar to the Administration's old CHIP bill. The other major NHI recommendations before Congress include the American Medical Association's Comprehensive Health Care Insurance Act, Labor's bill, the American Hospital Association's plan, and the Health Insurance companies' NHI proposal.

Under the Long bill:

- *All people would be covered by a catastrophic protection provision that would pay for everything above the cost of 60 days in a hospital or \$2,000 in expenses.

- *A uniform national benefit and eligibility structure with heavier federal contributions that would reshape the present Medicaid program and broaden it to include the "working poor."

- *Private health insurance carriers would have to meet government standards to qualify for par-

ticipation in the catastrophic and other federal health programs.

The catastrophic insurance could be provided by either the government through a one percent payroll tax or through employers' own insurance plans in which case employers could receive a 50 percent tax rebate. A separate Social Security trust fund would finance this provision.

* * *

Private health insurance organizations do a better and cheaper job of handling Medicare bills than the Social Security Administration, according to a General Accounting Office (GAO) report.

High federal pay and administrative inefficiencies were blamed for Social Security's poor showing in comparison with private organizations.

The report was sent to the House Ways and Means Committee which requested it last year. The Ways and Means Health Subcommittee will open Autumn legislative hearings soon on National Health Insurance. A major issue is whether a Social Security-financed catastrophic program should be part of NHI.

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ACCREDITED BY THE J. C. A. H.

GAO compared the SSA's Bureau of Health Insurance performance and cost for 1973 with that of four contract intermediaries—Mutual of Omaha, Travelers, the Maryland Blue Cross Plan, and Hospital Service Corporation (the Chicago Blue Cross Plan).

The GAO report found that the average cost, excluding audit, of a bill processed by SSA was \$12.39 compared to \$7.31 for Travelers, \$7.28 for Mutual, \$3.81 for Chicago, and \$3.55 for Maryland.

Social Security and intermediaries like Travelers and Mutual serve providers in a number of states, thus requiring field offices, and serve a higher percentage of skilled-nursing facilities, whose bills are considered more difficult to process than hospital bills, GAO said. "Such intermediaries can be expected to have higher costs than Blue Cross Plans, which primarily serve hospitals in only one state or part of a state," the report said.

GAO said it believes the Committee should allow HEW to redesignate an intermediary "when because of geographic dispersion, the provider's selection appears to inhibit efficient administration."

The report said Social Security's Administrative costs "substantially exceed the costs of Mutual and

Travelers. Higher salaries and lower productivity appear to be major reasons for the higher costs of the division, which, unlike the private intermediaries, had no production standards."

Social Security "generally took longer than the private intermediaries to pay bills and make final settlements with providers. Its error rate was about average," the report asserted.

Noting that personnel costs account for about 65 percent of an intermediary's expenses, GAO said Social Security personnel were consistently higher paid than personnel in comparable jobs with the four private intermediaries. "For example, accountants and auditors at Social Security were paid \$21,600 compared with an average \$15,900 in the private groups. Social Security claims examiners got \$11,600 compared with \$7,900; Registered Nurses \$13,600, compared with \$11,700.

Social Security's annual compensation exceeded the average annual compensation of the four private intermediaries by 36 percent for accountants and auditors, 47 percent for claims examiners, and 16 percent for Registered Nurses, the report said.

Book Reviews

Atlas of Pathologic Anatomy. By Wilhelm Doerr, Gerhild Schlumann and Günter Ule. 312 pages. Price DM 240 (approximately \$94.00). Stuttgart, West Germany: Georg Thieme, 1975.

Three authors and their associates spent 22 years collecting specimens and experimenting with color photography to produce this atlas. Little wonder that it may be the finest of its kind to appear in recent years.

Much of the microscopic material consists of large panoramic ("holoptic") tissue slices, rarely seen in standard medical publications and rarely present in pathologic laboratories because of their prohibitive cost. The photographs are on 9 x 12 cm lantern slides, providing superior histologic detail. Such innovations coupled with an excellent reproduction technique on a paper of finest quality have resulted in a true masterpiece of medical photography. The atlas proves once again that medicine in general and pathologic anatomy in particular are arts as well as sciences.

The atlas' 874 color photographs cover the gross and the microscopic morphology of a variety of lesions arranged according to organs and systems. The description of each photograph, concise yet adequate, contains the pathologic diagnosis, points out the per-

tinent pathologic features and gives information about the staining technique used and the size of magnification. The use of Latin is a help to readers who are not fluent in German.

This atlas is intended for use by physicians and medical students as an illustrative supplement to standard pathology books. It undoubtedly will also be of interest to connoisseurs and collectors of fine books in general.

MODESTO SCHARYJ, M.D.

The Dilemmas of Euthanasia. By John A. Behnke and Sassela Bok. 200 pages. Price \$2.95. New York: Anchor, 1975.

Suggestions of the Devil—The Origins of Madness. By Judith S. Neaman. 240 pages. Price \$2.50. New York: Anchor, 1975.

George III and the Mad Business. By Ida Macalpine and Richard Hunter. 407 pages. Price \$10.00. New York: Pantheon, 1970.

In our scientific era, we sometimes assume that our ways are infinitely superior to those of earlier societies, burdened as they were by superstition, plagues, religious wars and famines. With our sophis-

ticated nosologies and potent psychotropic drugs, our accelerating accumulation of neurophysiological and neurochemical data, certainly our care of the poor in the spirit must be better and our medical and legal weapons more effective. Yet there are those who question that recent reforms in the movement to assure mental health for all have been as far-reaching and as redemptive as their advocates assert. Arnhoff in a recent review (*Science* 188:1277-1281, 1975) has pointed to our failure to distinguish between our good intentions and the results of treatment of the mentally ill and has decried the lack of adequate research bearing on this dissociation, a distinction emphasized by the difficulties faced even by the Supreme Court in defining the grounds for confinement in mental institutions and the rights of patients to treatment. Implicit in such considerations is the necessity to clarify the degree of involvement and obligation of the state in the therapeutic system.

To better understand today's dilemmas, appreciation of how earlier societies faced similar problems might be beneficial. In the Middle Ages, the church was responsible for treatment with canon law and the legacy of Galenic medicine providing the nomenclature and theory for diagnosis. Yet as Neaman demonstrates, the medieval world was simply using different definitions; modern mathematics has contributed statistics to make, as Oppenheimer has pointed out, "room for human ignorance as an explicit factor in estimating the behavior of physical forces" whereas the ancients assumed that evaluation lay in the realm of God.

Because qualifying for heaven was then the prime purpose of life and a real devil could be blamed for

madness, therapeutic options unrecognizable today were available to both physicians and patient. One problem skirting the limits of medicine, law and religion today was of no concern—euthanasia. Without a technology, physical illnesses remained to be explained as aberrations of the humors, and treated accordingly. One of the problems considered by *The Dilemmas of Euthanasia*, "the extent of court's dominion over incompetent patients," is one of the themes of *Suggestions of the Devil*, if we substitute churches for courts. If the court orders heroic therapy and holds that disconnecting supporting apparatus may be homicidal, should the courts (society) assume financial responsibility if the patient survives in a vegetative state? In the tradition-directed societies of the Middle Ages, the question couldn't arise. In ours we ponder and write, write and ponder, sometimes as turgidly and pontifically as medieval theologians. For a classic example of legal hemming, hawing and obfuscation, only look to Cantor's contribution to *The Dilemmas*, a chapter entitled "Law and the Determination of an Incompetent Patient's Life-Preserving Care." Fortunately the essays by Bok, Reiser, Meyers, Crane and Cassell are well-tempered, reasonable and thought provoking. For the interested reader, Neaman's well-organized review provides an excellent background for Behnke's and Bok's collection. Macalpine and Hunter's *George III and the Mad Business* can be equally recommended for the more curious, both for its psychobiography of George III and its exploration of Georgian psychiatry—even more appropriate because of its insight into the workings of the mind of the Englishman most responsible for our bicentennial.

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In Memoriam

Albert Conners Jones, III, M.D.

Standing in the quiet, warmth and sun of South Carolina's rolling midland farm country gave insight to the roots of Al Jones. His father, just retired after 20 years as mayor of Batesburg, a quiet, keen, but gentle man. His mother, strong and courageous from her 40-year battle with rheumatoid arthritis, still using the Turkish pipe Al had fashioned for her so she could smoke during her long convalescent period after surgery at the Mayo Clinic.

Al went from these roots to Davidson College and then to the Medical College of South Carolina. There he married Beryl Rourke. After internship at Los Angeles County General, on to Africa for service at a missionary medical post—quite in keeping for this thoughtful, compassionate young physician.

After service in the United States Army, for which he received a commendation from the Surgeon General, he went to the Mayo Clinic for his training in internal medicine. He was a diplomate of the American Board of Internal Medicine and a member of the American College of Physicians.

During childhood summers with his family at Murrells Inlet, he developed a passion for the salt marshes, fishing, shrimping and crabbing that led him to choose Wilmington as his place to practice. This was carefully done because he wished for his boys to grow up near the ocean and the marshes that he loved.

Quiet and careful in his practice, as in his poling through the marshes, he developed a deep respect among his colleagues and the patients in his rapidly growing practice.

On June 16, 1975, this ended without warning—with shock, dismay and great loss to family, colleagues and community.

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Walter Thomas Tice, M.D.

High Point lost one of its most loyal, faithful and dedicated servants in the passing of Walter Thomas Tice, M.D., on April 16. He had been in declining health for several years and acutely ill four months. He had been a practicing physician in the city for 45 years.

Dr. Tice was born in Wadesboro August 26, 1903, a son of the late James H. and Minnie Pope Tice. He attended the Wadesboro schools and the University of North Carolina.

In 1925, he entered Jefferson Medical College in Philadelphia. He received his M.D. from Jefferson in 1927 and interned at Atlantic City Hospital for one year. While at Jefferson he became a member of Alpha Kappa Kappa, medical fraternity, and Alpha Omega Alpha Honorary Society. He did postgraduate work at the Mayo Clinic, Jefferson Medical College, Tulane University and the University of Chicago.

In 1928, he opened a general practice in Peachland, N.C., and in 1930 he moved to High Point and opened an office.

He was a veteran of World War II, serving as a major in the army from 1942 until September, 1945. He was awarded the Bronze Star.

He was past chief of staff of High Point Memorial Hospital and at the time of his death was a member of the executive committee of the staff (internal medicine and cardiology). He served on the Guilford County Board of Health in 1952 and in 1960 became a member of the Guilford County Board of Welfare, which he served as chairman.

He was a member and past president of the Guilford County Medical Society, a member of the American Medical Association, Southern Medical Association, North Carolina State Medical Society, American Society of Internal Medicine, New York Academy of Science, North Carolina Society of Internal Medicine, American College of Cardiology, Fellow of Royal Society of Medicine, London, and at the time of his death was serving on the Maryfield Nursing Home Advisory Council board of directors and several committees of the state medical society. He was a member of the Hiram Masonic Lodge, Woodmen of the World, Veterans of Foreign Wars, the American Legion and Junior Order.

He was a member of both Blue Shield and state nominating committees of the state society.

He was a member of the First Baptist Church and a teacher of the Thomas Bible Class. He served on the board of deacons and the finance committee and was past president of the church brotherhood.

On June 6, 1929, he married Bernice Keyser of Philadelphia, who survives along with two sons, Walter Thomas Tice, Jr. of Oak Ridge and Dr. John Keyser Tice of New Orleans; a sister, Mrs. Ernest (Mary) Ford of Lake Waccamaw; and three brothers, James H. Tice of Charlotte and Glenn and Ed A. Tice of Wadesboro.

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KEY TO ABBREVIATIONS

C—Correspondence
EMS—Emergency Medical Services

C&O—Committees & Organizations
BR—Book Review

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TRANSACTIONS

One Hundred Twenty-first Annual Session
held at
Pinehurst, North Carolina
May 1-4, 1975

Briefed and Abridged by
William N. Hilliard, Executive Director
North Carolina Medical Society
222 North Person Street, Raleigh, North Carolina 27611

NORTH CAROLINA MEDICAL SOCIETY

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<i>Vice-Councilor:</i>	Joseph A. Gill, M.D., 1202 Carolina Ave., Elizabeth City 27909 (1977)
<i>Second District:</i>	J. Benjamin Warren, M.D., Box 1465, New Bern 28560 (1976)
<i>Vice-Councilor:</i>	Charles F. Nicholson, Jr., M.D., 3108 Arendell St., Morehead City 28557 (1976)
<i>Third District:</i>	E. Thomas Marshburn, Jr., M.D., 1515 Doctors Circle, Wilmington 28401 (1976)
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<i>Fourth District:</i>	Harry H. Weathers, M.D., Central Medical Clinic, Roanoke Rapids 27870 (1977)
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<i>Fifth District:</i>	August M. Oelrich, M.D., Box 1169, Sanford 27330 (1978)
<i>Vice-Councilor:</i>	Bruce B. Blackmon, M.D., P. O. Box 8, Buies Creek 27506 (1978)
<i>Sixth District:</i>	J. Kempton Jones, M.D., 1001 S. Hamilton Rd., Chapel Hill 27514 (1977)
<i>Vice-Councilor:</i>	W. Beverly Tucker, M.D., Box 988, Henderson 27536 (1977)
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<i>Eighth District:</i>	Ernest B. Spangler, M.D., Drawer X3, Greensboro 27402 (1976)
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<i>Vice-Councilor:</i>	Otis B. Michael, M.D., Suite 208, Doctors Bldg., Asheville 28801 (1978)

SECTION CHAIRMEN—1975-76

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<i>Dermatology:</i>	George W. Crane, Jr., M.D., 1200 Broad St., Durham 27705
<i>Family Physicians:</i>	William W. Hedrick, M.D., 3311 N. Boulevard, Raleigh 27604
<i>Internal Medicine:</i>	James H. Black, M.D., 1351 Durwood Drive, Charlotte 28204
<i>Neurology & Psychiatry:</i>	Hervy W. Mead, M.D., 1900 Randolph Rd., Ste. 900, Charlotte 28207
<i>Neurological Surgery:</i>	M. Stephen Mahaley, Jr., M.D., 3940 Nottaway Rd., Durham 27707
<i>Obstetrics & Gynecology:</i>	C. T. Daniel, Jr., M.D., 1641 Owen Dr., Fayetteville 28304
<i>Ophthalmology:</i>	E. R. Wilkerson, Jr., M.D., 1012 Kings Dr., Charlotte 28207
<i>Orthopaedics:</i>	Frank C. Wilson, M.D., N. C. Memorial Hospital, Chapel Hill 27514
<i>Otolaryngology:</i>	N. L. Sparrow, M.D., 3614 Haworth Dr., Raleigh 27609
<i>Pathology:</i>	R. Page Hudson, M.D., Box 2488, Chapel Hill 27514
<i>Pediatrics:</i>	Gerard Marder, M.D., 224 New Hope Road, Gastonia 28052
<i>Public Health & Education:</i>	J. N. MacCormack, M.D., Box 2091, Raleigh 27602
<i>Radiology:</i>	R. W. McConnell, M.D., 1711 W. 6th St., Greenville 27834
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<i>Students, Medical:</i>	

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DAVID G. WELTON, M.D., 3535 Randolph Road, Charlotte 28211—2 year term (January 1, 1975 to December 31, 1976)

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1975

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Chronic Illness	27	Social Services Programs	36
Community Medical Care	28	Advisory to Medical Students	36
Comprehensive Health Services Planning	28	ad hoc Committee on Fees	36
Constitution & Bylaws	28	Board of Medical Examiners	37
Credentials	28	North Carolina Medical Care Commission	37
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Compilation of Annual Reports

CONSTITUTIONAL SECRETARY

The North Carolina Medical Society continues its previously noted growth. There is a total increase of 178 members since last year. The end of year membership figures for the past three years are as follows:

	1972	1973	1974
Total Members	4,122	4,297	4,475
Life Members	257	286	285
Student Members	57	108	106
Intern-Resident Members	20	28	48

The past year has seen the beginning of an effective post-graduate education program sponsored by the Society. The educational sessions at the annual meeting were superb, and attendance was the best in many, many years. The North Carolina Peer Review Foundation has established itself as an effective independent organization, and it is hoped that the education activities of the Society can respond to needs as evidenced by Peer Review throughout the State.

E. Harvey Estes, Jr., M.D.

REPORT OF EXECUTIVE DIRECTOR

Problems relating to the availability of professional liability insurance for the medical profession in North Carolina has undoubtedly been the dominant concern of both staff and society members during the Medical Society year encompassing the period of this report. While the problem is not yet resolved, the subject is under constant review and every possible solution to the problem is being explored by staff members and by officers of the Society.

During the period of this report there has been some reorganization of the headquarters staff in an effort to make it a more efficiently operating team and to accommodate the best capabilities of all members. Several reassignments of duties were effected under the reorganization and each staff member has certainly exemplified an outstanding effort of accomplishing the tasks assigned and each has contributed to the team approach of the work of the Headquarters office.

Two new Field Representatives were employed during 1974. Mr. Michael F. Cates joined the staff on July 8, 1974, and Mr. John M. Evenson joined the staff on August 19, 1974. Each has shown a capacity for growth and a maturing ability to accomplish whatever tasks may have been assigned.

Other staff members were given increased responsibility and new title assignments commensurate with their new duties as follows:

Mr. Gene L. Sauls was named Director, Field Service, and given overall responsibility for the activities of the Field Service and in addition has continued with most of his previous assignments and responsibilities including the physician placement service and staffing responsibility for a number of Committees.

Mrs. LaRue King had the title of Convention Coordinator added to her previous title of Assistant to the Executive Director in order to more appropriately reflect her responsibilities relative to the Annual Meeting program and the staffing responsibility for the Committees assigned to the Annual Convention Commission.

Mr. Stephen C. Morrisette was given the title of Director, Governmental Affairs and assigned primarily to legislative and governmental liaison activities in keeping with the recommendations of the Committee on Legislation. He continues the staffing responsibility for a number of Society committees.

Mr. Garland Pace continues as Controller administering most of the financial affairs of the Society, supervision of the operation and maintenance of the Headquarters Building as well as the staffing responsibility for the Committees under the Administration Commission.

All of these staff members, along with the secretarial, graphic art, and filing staff are capable and loyal to the Medical Society needs. They deserve your support and appreciation. The Executive Director is most assuredly appreciative of their daily efforts.

On December 30, 1974, the membership of the State Society stood at 4,475 as compared with 4,297 on that same date for 1973. As of April 1, 1975, there were 4,264 members of the State Society after taking into account deceased members during the past year and members who have moved out-of-state. As of April 1, 1974, there were 4,059 members of the State Society. One must recognize that there are a few slow paying members who have not yet paid their 1975 dues, but we do hope to collect their dues within the next few weeks so that we will again undoubtedly show a net gain in membership before too much more of 1975 has elapsed.

Including Student and Intern-Resident members, 117 new members have already joined the Society this year. So the membership in the State Society continues to grow at a moderate but steady rate during the 1974-75 Society year. This same growth does not hold true for the membership in the American Medical Association among the members of the North Carolina Medical Society. As of the April 1, 1975, date, there were only 2,575 members of the AMA as compared with 3,515 AMA members from North Carolina

on this same date in 1974. All levels of the medical organization needs a strong membership now more than ever before.

A copy of the Auditor's Report is contained in this compilation of Annual Reports reflecting that all funds and assets of the Society have been properly accounted for on the books of the Society in conformity with generally accepted accounting principles for non-profit organizations. The Audit Report as submitted by A. T. Allen & Company, dated January 17, 1975, stands as a self-explanatory report of my responsibility as Treasurer for the calendar year 1974 and is recommended for your approval.

The Audit Report also reflects the 1974 management of the *North Carolina Medical Journal* and this portion of the Audit Report is offered as a report of the business affairs of

the Journal from the Business Manager. The decline in advertising revenue continued for another year, reflecting somewhat the economic trends apparent in most enterprises in this country in the past 12 months. The expense of publishing the Journal was curtailed slightly even in the face of inflationary pressures for products and consumed items necessary to its production.

Most annual projects and activities of the Society have continued in a manner similar to previous years. A member of the Headquarters Staff has attended 27 County Medical Society meetings during the latter half of 1974 and the first three months of 1975. We feel that this is an appropriate effort of visitation in keeping with our desire to try and be of assistance to local societies.

William N. Hilliard, Executive Director

AUDITOR'S REPORT
NORTH CAROLINA MEDICAL SOCIETY
 Raleigh, North Carolina

12 Months Ended December 31, 1974

OFFICERS

Frank R. Reynolds, M.D.	President	Wilmington, N.C.
James E. Davis, M.D.	President-Elect	Durham, N.C.
Jack Hughes, M.D.	First Vice-President	Durham, N.C.
M. Frank Sohmer, M.D.	Second Vice-President	Winston-Salem, N.C.
E. Harvey Estes, Jr., M.D.	Secretary	Durham, N.C.
Chalmers R. Carr, M.D.	Speaker of the House	Charlotte, N.C.
Henry J. Carr, Jr., M.D.	Vice-Speaker of the House	Clinton, N.C.
George G. Gilbert, M.D.	Past President	Asheville, N.C.
William N. Hilliard	Executive Director - Treasurer	Raleigh, N.C.

Chairman and Members of the Finance Committee
 North Carolina Medical Society
 Raleigh, North Carolina

Gentlemen:

Pursuant to engagement, we have audited the books and records of the North Carolina Medical Society, Raleigh, North Carolina, for the period beginning January 1, 1974, and ending December 31, 1974, and present herewith our report.

EXHIBITS AND SCHEDULES

In presenting our findings, as the result of the audit, we have prepared four Exhibits and two Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Comparative Balance Sheet — Exhibit "A":

The first statement is a list of the Assets, Liabilities, Reserves, and Fund Balances, which we designate as Comparative Balance Sheet, for the year 1974, Exhibit "A", (with comparative figures for 1973). This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities, and Reserves. The other has been designated as a Capital or Non-Operating Fund containing the office equipment, real estate and capital stock owned and used by the Medical Society.

The Cash on Hand and in Bank is made up of \$75.00 Petty Cash Funds and \$316,079.14 in a checking account at First-Citizens Bank & Trust Company, Raleigh, North Carolina. Also, there was \$46,879.13 in regular savings account, \$151,054.11 in a certificate of deposit, and \$20,000.00 in a savings bond with the same Bank. There was \$40,000.00 in the local Savings and Loan Associations. The Cash in Bank was verified through reconciliations of the balances as shown by the records of the Medical Society with confirmations obtained independently from the banks. See Schedule 1 of this report for details.

Accounts Receivable — Regular in the amount of \$8,016.58 are shown on the Balance Sheet. The balance represents the total of several uncollected balances due for local advertising in the State Medical Journal, and other miscellaneous receivables.

Accounts Receivable — National Advertising in the amount of \$2,846.69 represent November and December 1974 National Advertising in the State Medical Journal.

Accrued Interest Receivable includes interest on three savings certificates totaling \$5,596.74, and \$3,359.48 delinquent interest due from International Developers, Inc., on a Notes Receivable from the sale of land.

Air Travel Deposit of \$425.00 is cash deposited with Eastern Airlines for air travel credit cards.

The Medical Society has a Notes Receivable and Deed of Trust, with balance due, of \$179,172.42 from International Developers, Inc., dated December 20, 1972, due each ninety (90) days for ten (10) years, at 7½% interest, payments at \$7,330.62 including interest, beginning March 20, 1973. The December 10, 1974 quarterly payment was not made and is delinquent at the time of writing this report.

The real estate, capital stock and office equipment and furniture shown on the Balance Sheet in the amount of \$1,384,783.83, is listed in detail in Schedule 2. The items shown represent cost value of the equipment to the Medical Society as no depreciation has been recorded.

Under the "Liabilities" section, we have listed those accounts, expenses, etc., incurred prior to December 31, 1974, for which statements or accounts were rendered or payment was due.

The Accounts Payable — Trade, in the amount of \$10,833.18, represents unpaid accounts at December 31, 1974. Most of these items were paid during the course of the audit.

The \$2,714.00, Dues to be Refunded, represents State dues collected which are refundable to the members. The \$114,115.00, "Due American Medical Association", is 1975 AMA dues collected in 1974. At December 31, 1974, the Society had collected, from members \$6,780.00, for MEDPAC contributions and \$58,455.00 for county dues. These items will be remitted to the respective organization in regular course. The payroll taxes, \$5,211.65, were paid during the course of the audit.

The deferred credits of \$134,188.00 are for payments of \$4,100.00 received on technical exhibits space for the 1975 Convention, and \$130,088.00 on 1975 State membership dues. These remittances were received in 1974, and will be transferred to the income accounts in 1975.

The Reserve accounts set forth on Exhibit "A" are for specific purposes or specific projects, which normally last for periods longer than one year; therefore, special provisions are made to set aside funds for these specified Reserves. A new Reserve for Operating Reserve for \$92,900.00 was established last year, \$110,316.00 was added to the Reserve this year, resulting in a total Reserve of \$203,216.00. This new Reserve account is intended to eventually equal one year's operating costs.

The Fund Balance section of the Balance Sheet is comprised of two figures, \$233,219.63 being the surplus of the Current Operating Fund at the year end, and \$1,384,783.83 representing the balance of Capital Fund. It should be observed that all surplus in the Current Operating Fund would not be available for immediate use, since a material amount is made up of the \$179,172.42 Note Receivable from International Developers, Inc.

Comparative Statement of Fund Balances — Exhibit "B":

The second statement is an analysis of the changes in Fund Balances during the year and is detailed on Exhibit "B".

Comparative Statement of Income and Expenses — Exhibit "C":

A statement showing a budget comparison of the income and expenses for the twelve months period is given in Exhibit "C". This statement is, in effect, a statement of operations for the year, and by examination it may be observed that the Income of \$608,197.66 exceeds the Expenses of \$477,376.64 by \$130,821.02. There was included in the expenses \$3,522.26 in Equipment Expenditures. Eliminating these, we show a margin from operations of \$134,343.28.

Comparing with the budget, we see that actual income was more than anticipated. The main items accounting for this was the interest income received and the large increase in annual dues.

Further comparisons reveal that the total actual expenses were \$28,939.36 less than the budget provision.

Cash Receipts and Disbursements — Exhibit "D":

A statement showing in detail the cash receipts and disbursements of the Society during the year under review is shown on Exhibit "D".

We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their original source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

GENERAL COMMENTS

A surety bond covering faithful performance of Mr. William N. Hilliard, Executive Director, in the amount of \$100,000.00, is in force, held by the Medical Society and was examined by us. We also examined and found in force a Primary Commercial Blanket Honesty Bond in the amount of \$100,000.00; a fire insurance policy covering fire loss on new building of \$1,150,000.00; all office contents incidental to the use of the Society, in the amount of \$70,000.00; glass coverage is included under separate coverage; a Non-Automobile Schedule Policy; a standard Workmen's Compensation and Employer's Liability policy; a Comprehensive General Liability Policy and Catastrophic Liability Policy; and an Accident Policy on Officers, Delegates, and Staff.

We were extended every courtesy and cooperation during the course of the audit and we experienced no problems in obtaining the necessary information for this report.

SCOPE OF EXAMINATION AND OPINION

We have examined the balance sheet of the North Carolina Medical Society as of December 31, 1974, and the related statements of income and expense and fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and fund balances present fairly the financial position of the North Carolina Medical Society at December 31, 1974, and the result of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistent with that of the preceding year.

Respectfully submitted,
A.T. ALLEN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

Raleigh, North Carolina
January 17, 1975

NORTH CAROLINA MEDICAL SOCIETY
Raleigh, North Carolina

EXHIBIT "A"
COMPARATIVE BALANCE SHEET
For the Year 1974
(With Comparative Figures for 1973)

ASSETS:	1974	1973
CURRENT OPERATING FUND:		
Cash on Hand and in Banks — (Schedule — 1)	\$ 574,087.38	\$ 512,875.90
Accounts Receivable — Regular	8,016.58	3,790.92
Accounts Receivable — National Advertising	2,846.69	3,932.98
Accrued Interest Receivable — On Savings Certificates and Notes	8,956.22	1,159.00
Air Travel Deposit	425.00	425.00
Notes Receivable — International Developers, Inc.	179,172.42	190,653.75
TOTAL CURRENT OPERATING FUND	<u>\$ 773,504.29</u>	<u>\$ 712,837.55</u>
CAPITAL OR NON-OPERATING FUND — (SCHEDULE—2):		
Real Estate — Land — Lane and Person Streets, Raleigh, North Carolina	\$ 227,733.90	\$ 227,733.90
Real Estate — Headquarters Building, Raleigh, North Carolina	1,044,302.06	1,042,394.56
Real Estate — Two Houses and Lots, Raleigh, North Carolina	34,674.40	
Office Furniture and Fixtures	77,873.47	74,726.56
Capital Stock — Common — State Medical Journal Advertising Bureau, Inc.	200.00	200.00
TOTAL CAPITAL OR NON-OPERATING FUND	<u>\$1,384,783.83</u>	<u>\$1,345,055.02</u>
TOTAL ASSETS	<u><u>\$2,158,288.12</u></u>	<u><u>\$2,057,892.57</u></u>
LIABILITIES, RESERVES, AND FUND BALANCES:		
LIABILITIES:		
Accounts Payable — Trade	\$ 10,833.18	\$ 11,247.90
Dues to be Refunded	2,714.00	3,993.00
Due American Medical Association	114,115.00	130,795.00
Due American Medical Association — Dues in Escrow		430.00
Due County Medical Associations	58,455.00	53,428.00
Due MEDPAC	6,780.00	8,800.00
Federal and State Income Tax Withheld	3,998.24	3,487.81
Payroll Taxes Payable	1,213.41	811.77
TOTAL LIABILITIES	<u>\$ 198,108.83</u>	<u>\$ 212,993.48</u>
DEFERRED CREDITS:		
Advance Payments on Technical Exhibit Space at Convention	\$ 4,100.00	\$ 4,080.00
Advance Payment on State Membership Dues	130,088.00	144,515.00
Advance Rent from Tenant on Rental Income		1,142.09
TOTAL DEFERRED CREDITS	<u>\$ 134,188.00</u>	<u>\$ 149,737.09</u>
RESERVES:		
Reserve for Traffic Liability Safety Program	\$ 135.28	\$ 135.28
Reserve for Section on O and O		432.40
Reserve for Mental Health State Conference Programs	596.63	3,302.87
Reserve for Mental Health Contactorama Programs	3,539.92	3,539.92
Reserve for Operating Reserve	203,216.00	92,900.00
Reserve for Purchase of Equipment	500.00	
TOTAL RESERVES	<u>\$ 207,987.83</u>	<u>\$ 100,310.47</u>
FUND BALANCES:		
Current Operating Fund — (Exhibit "B")	\$ 233,219.63	\$ 249,796.51
Capital Fund — (Exhibit "B")	1,384,783.84	1,345,055.02
TOTAL FUND BALANCES	<u>\$1,618,003.46</u>	<u>\$1,594,851.53</u>
TOTAL LIABILITIES, RESERVES, AND FUND BALANCES	<u><u>\$2,158,288.12</u></u>	<u><u>\$2,057,892.57</u></u>

EXHIBIT "B"
COMPARATIVE STATEMENT OF FUND BALANCES
For The Year 1974
(With Comparative Figures for 1973)

CURRENT OPERATING FUND:	1974	1973
Balance — Beginning of Year	\$ 249,796.51	\$ 88,116.47
ADD: Net Profit From Operations	134,343.28	259,023.88
	<u>\$ 384,139.79</u>	<u>\$ 347,140.35</u>
 LESS: Transfer to New Reserve for Operating Reserve	 \$ 110,316.00	 \$ 92,900.00
Transfer to Reserve for Purchase of Equipment	500.00	
Office Furniture and Equipment Transferred to Capital Fund	3,522.26	3,827.53
Construction in Progress	1,907.50	616.31
House and Lot — Fonville Property	16,330.00	
House and Lot — Partin Property	18,344.40	
	<u>\$ 150,920.16</u>	<u>\$ 97,343.84</u>
TOTAL CURRENT OPERATING FUND — TO EXHIBIT "A"	*\$ 233,219.63	\$ 249,796.51
 CAPITAL FUND:		
Balance — Beginning of Year	\$1,345,055.02	\$1,340,611.18
ADD: Capital Expenditures from Current Operating Fund	3,522.26	3,827.53
Construction in Progress — From Current Operating Fund	1,907.50	616.31
House and Lot — Fonville Property	16,330.00	
House and Lot — Partin Property	18,344.40	
	<u>\$1,385,159.18</u>	<u>\$1,345,055.02</u>
LESS: Equipment Disposed of During the Year	375.35	
TOTAL CAPITAL FUND — TO EXHIBIT "A"	\$1,384,783.83	\$1,345,055.02
TOTAL FUND BALANCES — END OF YEAR	\$1,618,003.46	\$1,594,851.53

* FOOTNOTE: Total Current Operating Fund includes a long-term note receivable from International Developers, Inc., for \$179,172.42 at December 31, 1974; therefore, this figure should be deducted when computing available cash surplus. Available cash surplus — \$54,-047.21.

EXHIBIT "C"
STATEMENT OF INCOME AND EXPENSES
12 Months Ended December 31, 1974

	Budget Provisions	Actual	Difference Over (Under)
INCOME:			
Membership Dues — Current and Prior Years	\$376,000.00	\$436,366.00	\$ 60,366.00
Sales of Journals, Rosters and Value Scales	5,600.00	6,136.84	536.84
Revenue Unexpected	4,500.00	8,310.39	3,810.39
Sales of Technical Exhibit Space	10,560.00	11,920.00	1,360.00
Journal Advertising — Local	10,000.00	12,077.78	2,077.78
Journal Advertising — National	35,000.00	20,442.07	(14,557.93)
Commission (1%) from AMA for Dues Collected	7,500.00	12,178.69	4,678.69
Commission (1%) from MEDPAC for Dues Collected	220.00	308.85	88.85
Rental Income — Headquarters Facility	50,936.00	53,663.96	2,727.96
Interest Income	6,000.00	44,576.26	38,576.26
Book Proceeds — "Medicine in North Carolina"00	1,175.00	1,175.00
Rental Income — Residential Property00	1,041.82	1,041.82
TOTAL INCOME	<u>\$506,316.00</u>	<u>\$608,197.66</u>	<u>\$101,881.66</u>
 EXPENSES:			
Executive Budget:			
A-1 Expense — President	\$ 8,000.00	\$ 9,574.90	\$ 1,574.90
A-2 President's Secretarial Assistance	4,000.00	1,452.66	(2,547.34)
A-3 Travel — Secretary	1,000.00	.00	(1,000.00)
A-4 Salary — Executive Director — Treasurer	26,160.00	26,160.00	.00
A-5 Travel — Executive Director — Treasurer	6,500.00	6,025.38	(474.62)
A-6 Executive Office — Secretarial and Clerical Assistance	53,000.00	50,435.96	(2,564.04)
A-7 Executive Office — Equipment and Replacements	4,000.00	3,345.98	(654.02)
A-8 Expenses — Executive Office	20,000.00	20,998.27	998.27
A-9 Bonding — (In Effort to 1975)00	257.00	257.00
A-10 Auditing	2,300.00	2,232.75	(67.25)

	Budget Provisions	Actual	Difference Over (Under)
EXPENSES: (continued)			
A-11 Taxes — (Salary Tax)	7,600.00	8,140.05	540.05
A-12 Insurance: Fire, Liability and Comprehensive	2,200.00	2,075.00	(125.00)
A-13 Membership Record System and Machine Rental	10,400.00	9,309.26	(1,090.74)
A-14 Publications, Reports and Executive Aids	300.00	320.68	20.68
A-15 Salary — Assistant Executive Director	18,700.00	4,830.81	(13,869.19)
A-16 Travel — Assistant Executive Director	3,500.00	552.87	(2,947.13)
A-17 Salary — Assistant to Executive Director	14,550.00	14,850.00	300.00
A-18 Salary — Field Representative — (MC)	.00	4,641.75	4,641.75
A-19 Salary — Field Representative — (JE)	.00	3,883.38	3,883.38
A-22 Salary — Controller	16,600.00	16,600.00	.00
A-23 Salary — Director, Field Services	13,500.00	14,166.64	666.64
A-24 Salary — Director, Governmental Affairs	10,600.00	12,199.96	1,599.96
A-25 Travel — Field Representatives	6,000.00	6,623.15	623.15
Total Executive Budget	\$228,910.00	\$218,676.45	\$ (10,233.55)
Journal Budget:			
B-1 Publication of Journal	\$62,000.00	\$61,124.50	\$ (875.50)
B-5 Expenses — Editorial Office	850.00	857.37	7.37
B-6 Expenses — Business Manager's Office	925.00	813.48	(111.52)
B-7 Equipment — Business Manager's Office	100.00	176.28	76.28
B-8 Travel for Journal	100.00	-0-	(100.00)
B-9 Payroll Taxes	1,200.00	1,123.36	(76.64)
B-10 Sales Tax on Journal and Roster Sales	2,400.00	2,005.00	(395.00)
B-11 Journal Salaries	18,850.00	17,498.00	(1,352.00)
Total Journal Budget	\$86,425.00	\$83,597.99	\$ (2,827.01)
Intra-Functional Activity Budget:			
C-1 Expenses — Executive Council	\$ 4,500.00	\$ 3,623.57	\$ (876.43)
C-2 Expenses — Publication Council Minutes	5,500.00	5,394.74	(105.26)
C-3 Expenses — Legislative Committees	6,500.00	4,269.31	(2,230.69)
C-4 Expenses — Maternal Health Committee	300.00	.00	(300.00)
C-5 Expenses — Drug Abuse Committee	200.00	3.50	(196.50)
C-7 Expenses — Exhibits Committee	1,220.00	942.91	(277.09)
C-8 Expenses — Mental Health Committee	400.00	37.36	(362.64)
C-9 Expenses — Mediation Committee	500.00	1,658.81	1,158.81
C-11 Expenses — Committees in General (Including Committees Under \$100 Allocations)	4,500.00	4,803.81	303.81
C-13 Expenses — Occupational and Environmental Health	200.00	3.00	(197.00)
C-15 Expenses — Relative Value Committee	600.00	210.48	(389.52)
C-17 Expenses — Student AMA Committee	2,000.00	1,169.50	(830.50)
C-18 Expenses — Disaster Emergency Medical Care Committee	600.00	181.15	(418.85)
C-20 Expenses — Constitution and Bylaws Committee	500.00	65.59	(434.41)
C-24 Expenses — Anesthesia Study Committee	320.00	317.89	(2.11)
C-30 Expenses — Insurance Industry Committee	800.00	906.88	106.88
C-31 Expenses — Community Health Committee	500.00	523.65	23.65
C-34 Expenses — Programs for General Sessions Committee	1,500.00	1,500.00	.00
C-36 Expenses — Family Marriage Counseling Committee	500.00	.00	(500.00)
C-37 Expenses — Medicine and Religion Committee	350.00	164.45	(185.55)
C-49 Expenses — Medical Education Committee	1,000.00	446.61	(553.39)
C-51 Expenses — Medical Aspects of Sports Committee	1,000.00	756.88	(243.12)
C-53 Expenses — Allied Health Professions Committee	200.00	.00	(200.00)
C-58 Expenses — Peer Review Committee	200.00	.00	(200.00)
C-59 Expenses — Health Care Delivery Committee	750.00	.00	(750.00)
C-61 Expenses — Audio-Visual Programs Committee	150.00	9.57	(140.43)
Total Intra-Functional Activity Budget	\$34,790.00	\$26,989.66	\$ (7,800.34)
Extra-Functional Activity Budget:			
D-1 Expenses — Delegates to AMA	\$11,100.00	\$ 9,440.47	\$ (1,659.53)
D-2 Expenses — Conference Dues	250.00	257.50	7.50
D-3 Expenses — Woman's Auxiliary	5,400.00	5,900.00	500.00
D-5 Expenses — President's Communication Program (Newsletter)	1,350.00	1,563.75	213.75
Total Extra-Functional Activity Budget	\$18,100.00	\$17,161.72	\$ (938.28)

Public Relations Budget:

E-3 Committee Chairman — Out of State Travel	\$ 500.00	\$.00	(500.00)
E-9 Audio-Visual Depiction, Photography, Etc.	100.00	23.75	(76.25)
E-10 Educational Distributions — Materials	300.00	313.91	13.91
E-11 News and Press Releases	200.00	37.00	(163.00)
E-12 Public Relations Bulletin	3,800.00	3,666.71	(133.29)
E-13 State High School Science Fair Program	160.00	100.00	(60.00)
E-14 Exhibits and Displays	500.00	.00	(500.00)
E-15 Conference for Medical Leadership	1,500.00	1,025.08	(474.92)
E-17 Today's Health Magazine Subscriptions	850.00	.00	(850.00)
E-18 Collateral Public Relations	500.00	178.54	(321.46)
E-19 N.C. Rescue Squad First Aid Trophies	200.00	115.18	(84.82)
Total Public Relations Budget	\$8,610.00	\$5,460.17	\$(3,149.83)

Annual Sessions (120th) Convention Budget:

F-1 Program Production	\$ 2,000.00	\$ 2,419.51	\$ 419.51
F-2 Hotel and Auditorium Expense	5,000.00	6,319.45	1,319.45
F-3 Expenses — Publicity Promotion	600.00	592.42	(7.58)
F-4 Entertainment	1,200.00	1,271.37	71.37
F-5 Orchestra and Floor Entertainment	2,500.00	475.00	(2,025.00)
F-6 Guest Speakers	500.00	285.98	(214.02)
F-9 Booth Installation and Supplies	4,500.00	3,887.90	(612.10)
F-10 Projection Expense	800.00	508.55	(291.45)
F-11 Badges	250.00	115.96	(134.04)
F-12 Transactions Reporting Service	2,500.00	2,446.12	(53.88)
F-13 Rental — Extra Facilities	200.00	130.05	(69.95)
F-14 Exhibitors Entertainment	850.00	986.33	136.33
F-15 Banquet Expense	200.00	153.90	(46.10)
F-16 Police Security	390.00	406.88	16.88
Total Annual Sessions (120th) Convention Budget	\$21,490.00	\$19,999.42	\$(1,490.58)

Miscellaneous Budget:

G-1 Legal Counsel Retainer	\$16,800.00	\$19,032.85	\$ 2,232.85
G-2 Reporting (Executive Council, Etc.)	2,000.00	2,214.49	214.49
G-3 Fifty Year Club (Pins, Etc.)	350.00	385.87	35.87
G-4 Contingency and Emergency	3,229.00	3,316.52	87.52
G-5 Employees Retirement System	21,000.00	12,383.89	(8,616.11)
G-6 Ad Valorem Taxes	900.00	836.57	(63.43)
G-7 Association of Professions	200.00	200.00	.00
G-10 Expense of Commissioners	1,500.00	1,145.75	(354.25)
G-11 Expenses of Executive Committee	300.00	.00	(300.00)
G-12 Expenses of Officers to National Meetings	2,000.00	1,801.93	(198.07)
G-13 Travel and Maintenance, Expense of Essential Staff — Out-of-State Sessions	2,000.00	1,602.17	(397.83)
G-14 N.C.M.S. Headquarters Staff Hospitalization	2,262.00	2,858.05	596.05
G-15 Sales Tax — "Medicine in North Carolina"	.00	31.50	31.50
Total Miscellaneous Budget	\$52,541.00	\$45,809.59	\$(6,731.41)

Headquarters Facility Budget:

M-5 Utilities	\$ 15,000.00	\$ 18,875.78	\$ 3,875.78
M-6 Insurance	1,750.00	1,751.00	1.00
M-7 Taxes (Real Property)	16,200.00	16,629.79	429.79
M-8 Water	500.00	461.05	(38.95)
M-9 Janitorial Services	13,500.00	12,920.00	(580.00)
M-10 Grounds Maintenance	1,500.00	1,815.84	315.84
M-11 Building Repairs and Maintenance	4,000.00	4,222.53	222.53
M-12 Heating, Air Conditioner Repairs and Maintenance — (Elevator Maintenance)	3,000.00	3,005.65	5.65
Total Headquarters Facility Budget	\$ 55,450.00	\$ 59,681.64	\$ 4,231.64

TOTAL EXPENSES	\$506,316.00	\$477,376.64	\$(28,939.36)
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SUMMARY:		1974	1973
Total Income		\$ 608,197.66	\$692,163.14
LESS: EXPENSES:			
Executive Budget	\$218,676.45		\$193,674.73
Journal Budget	83,597.99		84,909.99
Intra-Functional Activity Budget	26,989.66		25,236.39
Extra-Functional Activity Budget	17,161.72		11,275.06
Public Relations Budget	5,460.17		5,902.83
Annual Sessions — Convention Budget	19,999.42		19,135.38
Miscellaneous Budget	45,809.59		46,055.13
Headquarters Facility Budget	59,681.64	477,376.64	155,977.28
EXCESS OF INCOME OVER EXPENSES		\$130,821.02	\$149,996.35
ADD: Capital Expenditures from Current Funds (Included Above)		3,522.26	109,027.53
NET MARGIN FROM OPERATIONS		<u>\$134,343.28</u>	<u>\$259,023.88</u>

EXHIBIT "D"

CASH RECEIPTS AND DISBURSEMENTS

12 Months Ended December 31, 1974

CASH ON HAND AND IN BANKS — JANUARY 1, 1974

\$ 512,875.90

ADD: CASH RECEIPTS:

Income from Operations — (Exhibit "C")	\$608,197.66
Decrease in Accounts Receivable — National	1,086.29
Receipts on Notes Receivable — International Developers, Inc. — Principal	11,481.33
AMA Dues Collected	364,327.00
County Dues Collected	159,511.00
MEDPAC Dues Collected	28,935.00
Increase in Payroll Taxes Unremitted	912.07
Advance Payments — Technical Exhibit Space — 1975	4,100.00
Advance Payments — State Membership Dues — 1975	130,088.00
LESS: Accrued Interest Receivable on Savings and Notes Receivable — Included in Income Above)	(7,797.22)

TOTAL CASH RECEIPTS 1,300,841.13

TOTAL FUNDS TO ACCOUNT FOR \$1,813,717.03

CASH DISBURSEMENTS:

Expenditures from Operations	\$477,376.64
Increase in Accounts Receivable — Regular	4,225.66
Purchase of House and Lot — Fonville Property	16,330.00
Purchase of House and Lot — Partin Property	18,344.40
Construction in Progress — Partitions	1,907.50
Decrease in AMA Escrow Funds	430.00
Accounts Payable — Trade — 12/31/73 — Paid in 1974	11,247.90
Decrease in Refunds Payable	1,279.00
AMA Dues Remittances	381,007.00
County Dues Remittances	154,484.00
MEDPAC Dues Remittances	30,995.00
Advance Payments — Technical Exhibit Space — 1974 — Transferred to 1974 Income	\$4,080.00
Advance Payments — State Membership Dues — 1974 — Transferred to 1974 Income	144,515.00
Advance Rent — 1974 — Transferred to 1974 Income	1,142.09
Transfer Reserve for O and O Funds to MEDPAC	432.40
Expenditures from Reserve for Mental Health State Conference Programs	2,706.24
LESS: Accounts Payable — Trade — 12/31/74 — Unremitted	(10,833.18)

TOTAL CASH DISBURSEMENTS \$1,239,629.65

CASH ON HAND AND IN BANKS — DECEMBER 31, 1974 574,087.38

TOTAL FUNDS ACCOUNTED FOR \$1,813,717.03

SCHEDULE — 1
CASH ON HAND AND IN BANKS (INCLUDING SAVINGS)
December 31, 1974

FIRST-CITIZENS BANK & TRUST COMPANY — RALEIGH, NORTH CAROLINA:

Checking Account — Number 12-03-643	\$316,079.14	
Savings Account — Number 0861010544	46,879.13	
Certificate of Deposit — Number 18,804	151,054.11	
Savings Bond — Number 39270-N	20,000.00	\$534,012.38

FIRST FEDERAL SAVINGS & LOAN ASSOCIATION — RALEIGH, NORTH CAROLINA:

Certificate of Deposit — Number 141,851	20,000.00
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RALEIGH SAVINGS & LOAN ASSOCIATION — RALEIGH, NORTH CAROLINA:

Certificate of Deposit — Number 5931	20,000.00
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PETTY CASH FUND — OFFICE

75.00

TOTAL CASH\$574,087.38

SCHEDULE — 2
SCHEDULE OF CAPITAL ASSETS
December 31, 1974

Quantity	Item	Date	Cost	Quantity	Item	Date	Cost
1	Steel Filing Cabinet		\$ 71.75	2	Five-Drawer Files — Gray		200.98
2	Gray Steel Filing Cabinets		103.00	1	Storage Cabinet		83.17
1	Four Drawer Steel				I.B.M. Equipment:		
	Filing Cabinet		78.03	17	Control Panels		374.27
1	Remington Rand Electric			1	Sorter Rack		49.70
	Adding Machine		215.01	5	Sets Manual Wire		
1	Metal Storage Cabinet		78.28		Complements		177.31
1	Metal Filing Cabinet		92.76	1	Twenty-Drawer Card File		284.96
1	Metal File and Sections		68.55	1	Control Panel Cabinet		71.54
2	Typewriters — Large Type			1	Mosler Fire-Proof File —		
	(Bulletin)		321.23		Four-Drawer		319.30
1	Metal File and Frames		93.07	3	Cory Five-Drawer		
1	Portable Lectern		29.93		Letter Files		290.95
1	Metal File		114.33	1	Cosco Secretarial Chair		30.85
1	Five-Drawer Letter File		122.78	1	Combo Binding Machine		46.95
2	Five-Drawer Files		245.56	1	Model L-H Letter Opener		58.71
1	A.B. Dick Offset Duplicator		3,204.53	1	18" Pendaflexor —		
2	Four-Drawer Durable Files		61.70		Two-Drawer		43.78
1	Postage Mailing Machine		855.70	7	Four-Drawer Files		223.51
1	Book Case Section No.			1	Underwood Electric Type-		
	813 Walnut		29.26		writer — 700 TW No.		
3	Letter Size Files		103.72		9694676		334.75
1	TU-24 Star Tube Roll File		40.00	1	Projection Pointer		97.00
1	122 H Steel Cart W/3 Shelves		35.76	2	Shelving Units		66.95
6	Four-Drawer Letter Size Files		199.31	1	Eight Station Collator —		
1	Electric Projection Pointer		77.15		Paper Gatherer		346.55
1	Toledo Postage Scale (Used)		154.50	1	3 M Portable Compact Copier		69.95
1	Three Section Book Case		137.61	1	TU-DROR Pendaflexor		
1	Divisumma 24 Calculator		627.79		File		63.86
1	Walnut Dictionary Stand		67.07	1	Electrosumma 20 Adding		
4	Side Chairs		73.05		Machine No. 6638949		184.89
1	No. 1900 Addressograph		500.00	1	Dual Purpose Hand Truck		47.51
1	Carrying Case for Adding			1	Desk — Walnut Finish		118.97
	Machine		18.49	1	Remington Electric Typewriter		
1	Four-Drawer Letter File		173.66		No. 634800		424.01
1	Four-Drawer No. 24-A File			1	Remington Electric Type-		
	Cabinet		41.95		writer No. 635838		424.00
1	Remington Typewriter			1	Four-Drawer File		
	No. 3064244		388.90		(Dr. Styron)		88.60
1	Hand Truck		13.59	1	Used Copying Machine —		
1	Section Steel Shelving		123.60		A.B. Dick No. 675		1,000.00
1	Scriptor 13" Elite Electric			1	Supply Cabinet		37.00
	Typewriter No. 9709767		311.85	1	Storage Cabinet		37.00
4	No. 8 B 51 Five Drawer Files		401.78	1	Metal Letter File with Lock		61.60
1	Electric Pencil Sharpener		34.98	1	Storage Cabinet		37.00
1	Feeder Unit for			1	Royal Typewriter		
	Addressograph		936.53		No. 4132-506		133.31
1	Scriptor Electric Typewriter			1	Four-Drawer Metal File		69.49
	No. 1089421		366.17	1	Two-Drawer Metal File		18.36

COMPILATION OF ANNUAL REPORTS

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Quantity	Item	Date	Cost	Quantity	Item	Date	Cost
1	Supply Cabinet		75.00	2	72 US-BS Chairs	3/24/71	188.74
1	Metal Storage Cabinet		57.29	1	1503 WRC Desk	3/24/71	312.45
1	Folder Machine and A.B. Dick Stand		397.88	2	72 UBC Chairs	3/24/71	141.63
1	Model DLS Screen		32.45	1	1590 Table	3/24/71	234.19
1	Record Player		101.25	4	68S-BS Chairs	3/24/71	662.40
1	Microphone and Stand		19.40	1	8623 Ash Tray	3/24/71	12.67
1	Slide Projector — With Case ..		94.47	1	10 N-10 M Waste Basket	3/24/71	24.25
1	Lectern Mike		56.85	1	2-W Letter Tray	3/24/71	20.39
1	Camera and Flash		88.98	1	19-9 Pot Cover	3/24/71	8.82
1	Metal File		95.79	1	1503 WRC Desk	3/24/71	312.45
2	Four-Drawer Files		194.47	1	541 WRC Credenza	3/24/71	285.44
1	Underwood Scriptor Electric Typewriter No. 21-8721980 ..		337.64	2	72 UBC Chairs	3/24/71	138.81
1	Crestline Deluxe Projector		79.26	1	704 BC Sofa Bed	3/24/71	472.52
1	Carri-Voice and Revere Tape Recorder No. 3001 312		480.00	1	65 ABC Chair	3/24/71	262.58
2	8 B 51 Gray File Cabinets		236.66	1	2511 Table	3/24/71	159.80
1	8 B 51 Gray File Cabinet		100.57	1	10 N-10 M Waste Basket	3/24/71	24.25
1	Five-Drawer Gray File Cabinet		100.48	1	2-W Letter Tray	3/24/71	20.39
1	Bell & Howell Projector		175.00	19	1258 DS Chairs	3/24/71	2,946.30
2	Four-Drawer File		63.86	12	1255 Chairs	3/24/71	1,509.92
2	Cory Five-Drawer Files		228.66	2	544 WR Wall Cabinets	3/24/71	548.85
1	Olympia Electric Typewriter .. No. 27-494032		431.05	1	19-12 Pot Cover	3/24/71	16.53
1	Steel File		88.27	2	65 BC Chairs	3/24/71	436.43
2	Four-Drawer Files		63.86	1	2562 WRBC Table	3/24/71	67.77
1	Portable Lectern		29.67	4	72 US-BS Chairs	3/24/71	349.35
1	Eight Yard Dempster Dump- Master Sanco Corporation ..	3/19/71	528.37	1	Frigidaire Refrigerator — Tuttle	4/15/71	349.68
4	Floor Ash Trays — Duk-It — ROS	3/24/71	96.00	1	Frigidaire Range	4/15/71	246.17
3	Dual Receptacle Duk-It	3/24/71	117.00	2	Royal Metal 30 X 75	4/30/71	228.50
5	Duk-It Black Letter Trays	3/24/71	37.50	1	Conference Table	4/30/71	104.22
42	No. 1605 Ash Trays	3/24/71	126.0	6	Alma Book Cases	4/30/71	495.72
6	Duk-It Waste Baskets	3/24/71	66.60	4	Wall Poles	4/30/71	31.44
9	Duk-It Calendars and Bases	3/24/71	21.60	2	File Units	4/30/71	175.22
8	No. 1607 Ash Trays — Duk-It	3/24/71	31.20	1	Sliding Door Cabinet	4/30/71	53.35
3	Duk-It Ice Water Pitcher & Tray	3/24/71	126.00	6	Alma Shelves	4/30/71	47.17
6	No. 6023 Chairs — Serapi Blue — Navaho Fabric	3/24/71	497.88	1	Cory Library Table	4/30/71	195.77
2	No. 6023 Chairs — Soot Black — Navaho Fabric	3/24/71	165.96	6	All Steel Black Desks — A. Williams	4/30/71	1,602.54
10	No. 6055 UA Chairs — Ebony — Navaho Fabric	3/24/71	1,940.40	1	All Steel Black Table 36 X 36	4/30/71	66.31
22	No. 1086 Howe Folding Tables	3/24/71	2,640.00	1	Lectern	4/30/71	68.22
4	2530 Bench — DG	3/24/71	940.36	1	Chalkboard	4/30/71	67.06
3	19-12 Pot Cover	3/24/71	49.59	1	Conference Table — Oil Walnut Finish	4/30/71	3,982.50
1	67 BC Sofa	3/24/71	613.87	1	Lectern — Oil Walnut Finish ..	4/30/71	239.99
2	65 BC Chairs	3/24/71	487.13	2	Tables — White — 163 F	4/30/71	100.29
1	252 Coffee Table	3/24/71	242.46	12	1258 DS Chairs — Red Fabric	4/30/71	1,863.78
3	19-12 Pot Cover	3/24/71	49.59	3	Clocks — HM Black Case — Storr Sales	4/30/71	139.21
1	8623 Ash Tray	3/24/71	12.67	7	Draperies — Weaver Textile ..	5/28/71	6,620.21
150	1601-G Stacking Chair	3/24/71	2,295.75	1	Art Metal Bookcase Sections — Storr Sales	6/25/71	551.06
8	1600-1 Dolly	3/24/71	132.25	1	Vogel Peterson Costumer, Wall Shelf and Coat Hangers	6/25/71	80.42
4	309 F-2 Table	3/24/71	262.30	1	Chair and Table — ROS	6/25/71	152.98
16	1601 Stacking Chair	3/24/71	238.05	1	Toro Lawn Mower — Flythe ..	7/09/71	124.58
2	72 UBC Chairs	3/24/71	138.32	2	1-W Letter Trays — D.G.	7/09/71	20.59
4	72 US-BS Chairs	3/24/71	349.37	2	72 US-BS Chairs	7/09/71	201.32
6	1514 WRC Desks	3/24/71	1,384.28	1	10-N Waste Basket	7/09/71	17.73
1	1519 WRC Table Desk	3/24/71	215.47	1	2562 WR/BC TABC	7/09/71	78.06
1	1546 WRC Secretarial Desk ..	3/24/71	367.55	4	Bookcase Sections and One End Panel No. 2118 — Storr Sales	9/07/71	342.31
6	541 WRC Credenzas	3/24/71	1,776.66	6	No. 800 Walnut Oil Shelves — E and B	10/21/71	63.65
1	541 WRC Credenza	3/24/71	333.38	4	Lockers — Gray Finish	12/23/71	186.70
1	541 Credenza	3/24/71	409.43	1	560 R Pedestal Desk and Chair — Storr Sales	11/23/71	395.30
8	72 UBC Chairs	3/24/71	585.25	1	Twenty-Drawer Card File — Clyde Rudd	2/11/71	210.73
6	72 UBC Chairs	3/24/71	457.09	1	Drain Board for Printing Room — Montgomery-Green	5/12/71	72.10
2	72 UBC Chairs	3/24/71	179.64	1	Control Panel Cabinet — Tab Products	5/12/71	87.86
8	10 N-10 Waste Baskets	3/24/71	193.97				
8	2 W Letter Trays	3/24/71	163.11				

Quantity	Item	Date	Cost
1	Edison-Voicewriter — T.A. Edison Ind.	7/19/71	1,548.46
1	File Cabinet — W.B. Bunn	11/23/71	150.00
1	Bates Electric Stapler — #56	3/08/72	72.28
2	IBM Selectric II Typewriters ..	5/15/71	1,268.80
1	IBM Selectric II Typewriter ...	12/08/72	634.40
2	IBM Selectric II Typewriter ...	4/26/73	1,268.80
2	Stencraft Storage Cabinets	8/17/73	133.12
1	Bookcase — Oil Walnut	9/13/73	101.09
5	Panasonic Tape Recorders	10/08/73	389.64
1	Ricoh Electronic Calculator ...	12/21/73	462.80
1	NuArc Light Table — (Lay-Out)	11/28/73	182.00
1	IBM Electric Typewriter	12/31/73	717.60
1	Envelope Detacher	12/31/73	281.33
1	Sonyo Recorder	12/31/73	291.15
1	A.B. Dick — Model 106 — Plate Developer	2/22/74	152.88
1	Craig Transcriber — Recorder	5/07/74	108.36
1	Offset Plates — Used	5/07/74	125.00
1	Challenge 16" Paper Cutter — Used	6/21/74	200.00
1	Steelcase Desk and Return	8/26/74	436.16
1	Secretarial Chair — GF	8/26/74	155.58
3	Folding Tables	8/26/74	171.27
9	2-W Letter Trays	9/11/74	269.63
3	Walnut Top Tables	8/11/74	330.64
1	F and E Checkwriter	10/23/74	249.60
6	Chairs — DG — Blue	11/19/74	646.86
1	Smith-Corona Typewriter — (Journal)	10/09/74	176.28
3	IBM Files — Used — (BME)	12/30/74	500.00
TOTAL OFFICE FURNITURE AND FIXTURES			\$ 77,873.47

REAL ESTATE:

Land — Lane and Person Streets, Raleigh, North Carolina	227,733.90
New Headquarters Facility Building Raleigh, North Carolina	1,044,302.06
House and Lot — Fonville Property — Raleigh, North Carolina	16,330.00
House and Lot — Partin Property — Raleigh, North Carolina	18,344.40

OTHER ASSETS:

Capital Stock — State Medical Journal Advertising Bureau, Inc.	200.00
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TOTAL CAPITAL ASSETS —

TO EXHIBIT "A" \$1,384,783.83

REPORT FROM THE WOMEN'S AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

1974-75 has been a productive year for the Auxiliary.

At our annual meeting in May 1974, our delegates approved a comprehensive revision of our Constitution and Bylaws. Also approved was an increase in dues. These two actions have increased our ability to implement our aims and goals in a rapidly changing society.

Our theme this year has been "Communication, Cooperation, and Education."

Realizing the validity of the maxim, "You can't sell it unless you tell it," we have increased our efforts to create an awareness of the contribution made to society by doctors and their wives.

Many of our auxiliaries have inaugurated newsletters this year as a medium to COMMUNICATE to their members and to other organizations. Through the generosity of the North Carolina Medical Journal we have reached the over 4000 members of the Medical Society and their wives in a monthly column in the Journal. Our Auxiliary newspaper, *Tarheel Tandem*, is sent to our 2800 members, to the leading newspapers over the state, and to over 200 diverse individuals and organizations in our state and country.

We have COOPERATED with our medical schools, our medical societies and other organizations to sponsor workshops and symposiums on such health-related topics as V.D., Learning Disabilities and Child Abuse. Auxiliary members are working actively in all areas in their communities, serving on boards of practically every community organization.

Thus, by COMMUNICATING and COOPERATING, we are EDUCATING.

The cooperation we have received from the Headquarters staff has been outstanding. My particular thanks to Mr. William Hilliard, Mrs. LaRue King, and Mrs. Jackie Cutrell who have assisted me in so many ways. We have enjoyed using the Auxiliary office for several committee meetings, as well as the Council Room for the Mid-Winter Conference.

Dr. Gloria Graham, Chairman of the Advisory Committee has been extremely interested and enthusiastic over Auxiliary accomplishments, and most helpful with her guidance and suggestions. The Advisory Committee and the Medical Society have been most gracious and generous to both the Auxiliary and me.

Dr. Frank Reynolds, President of the Medical Society, has been a stalwart supporter of Auxiliary, generous with both his time and knowledge. It has been a pleasure to work with him.

Realizing that our Auxiliary is the vital link between the AMA Auxiliary and the county Auxiliaries we have constantly worked to strengthen these ties. We have utilized the material and manpower of the AMA Auxiliary to train leaders to go back to their communities and implement the aims of our Medical Society and Auxiliary.

WORKSHOPS: In order to assist incoming county officers in planning their year's work we held a Program Planning Workshop at our Annual Convention in May 1974. Areas of emphasis were AMA/ERF, Legislation, Ecology, V.D., Language Disability, Child Abuse, Health Fairs, and Publicity. Seventy-six members, including our AMA Auxiliary President, attended.

In the fall we held two workshops — one in the western part of the state and one in the eastern part. All phases of Auxiliary work were presented by the respective State

Chairmen. The keynote speaker, Mrs. Woodard Farmer, emphasized the Auxiliary's role in Learning Disabilities. The total registration (169) was the largest in the history of Fall Workshops.

On February 1, 1975, in conjunction with the Society's Midwinter Conference, the Auxiliary held a Leadership Workshop. Recognizing that doctor's wives are leaders not only in Auxiliary, but in many other community organizations, the workshop featured training in such skills as Parliamentary Procedure, Publicity Procurement, and Public Speaking.

All of these workshops have been "open" to all Auxiliary members, and we have had an overwhelming attendance and response to these training sessions.

MEMBERSHIP: Realizing that membership is the cornerstone of all our activities, we have placed special emphasis on recruitment, training, and retention of members.

We have tried several approaches: (1) Encouraged several small auxiliaries to combine into one auxiliary (2) Encouraged active auxiliaries to take Members-at-Large and faltering auxiliaries into their auxiliary (3) Worked with Members-at-Large to reorganize counties which have disbanded in the past. At the time of this writing, (February 1), five counties have either reorganized or joined with an organized auxiliary. Meetings with doctor's wives in several more unorganized counties are scheduled in February. Practically every Member-at-Large has been invited to attend meetings in surrounding counties. Our membership as of February 1 is 2,625.

AMA/ERF: The American Medical Association—Education Research Foundation continues to be the only philanthropic endeavor sponsored by the WA/AMA. Every county auxiliary contributes in some manner to this project. North Carolina has also become part of "Project Credit" where all donations from North Carolina will go on record for our Auxiliary. Dr. Gloria Graham, our Advisor, has wholeheartedly supported our efforts by bringing the needs of AMA/ERF to the attention of all members of the Medical Society. At this time, our total 1974-75 donation to AMA/ERF is \$15,456 and we have several more months to go in our fiscal year.

STUDENT LOAN: Unusually large demands have been made on our state Student Loan program this year. Outstanding loans now total \$28,559, one-third of which was loaned during the past year. Local scholarships and loans to students in Health fields continue to be the most frequently mentioned project of our county auxiliaries.

MENTAL HEALTH RESEARCH ENDOWMENT FUND: Our Mental Health Research Endowment Fund is complete at \$20,700. The interest continues to go to the Department of Psychiatry, University of North Carolina at Chapel Hill. This past year the fund was used for research on severely unsocialized children and their parents.

SANATORIA BEDS: The Auxiliary continues to support four endowed beds at our state Sanatoria. We are re-evaluating these funds in light of changes in needs at the Sanatoria. The total endowment for these four beds is \$42,000.

LEGISLATION: We have worked closely with Mr. Steve Morrisette of Headquarters on Legislation, as well as utilizing our own letterwriting network on crucial legislation. This was an election year and we worked diligently to elect candidates sympathetic to the cause of medicine. Our membership in AMPAC/MEDPAC as of February 1, is 217 a new high for auxiliary membership.

COMMUNITY HEALTH AND FAMILY HEALTH: Much work has been done in these two interrelated fields. Many auxiliaries assisted with Bloodmobile (one auxiliary established a Blood Bank for its local hospital), sponsored GEMS (baby sitting) courses (one auxiliary trained 217 students), and continued the fight against V.D. by showing the film "V.D. — a New Focus," providing speakers and materials for schools (one auxiliary held a V.D. Workshop for all Jr. High teachers of Health). Many auxiliaries are continuing their work with Child Abuse, sponsoring forums and working with other organizations to make the public more aware of this problem and what can be done. Learning Disabilities has been one of our main areas of concern. The North Carolina Auxiliary cooperated with the Forsyth-Stokes Auxiliary and Bowman Gray Medical School to sponsor a Learning Disabilities Symposium on February 22. Our Health Fairs have mushroomed. They are being held in more communities each year and are reaching more students in these communities.

HEALTH EDUCATION: Mrs. Edwin Martinat's survey on Health Education in the North Carolina Medical Journal brought the Auxiliary much favorable comment for its work in pinpointing the needs in Health Education. The Medical Society and Auxiliary are cooperating with the North Carolina Department of Public Instruction to

explore and develop effective curricula and teaching methods.

Our full quota of delegates attended both the WA/AMA Convention and the National Fall Conference in Chicago. All representatives invited to the Southern Regional Workshop in New Orleans were present with briefcases full of reports of our exciting projects to share with other states.

I have attended all District and County Auxiliary meetings to which I have been invited, criss-crossing the state many times in my travels. I have also represented the Auxiliary at other meetings throughout this state and other states.

This has been a busy, challenging year. My Executive Committee and Board of Directors have been of invaluable help. I am grateful to the members of the Auxiliary to the North Carolina Medical Society for the opportunity of serving as their president, and for their support throughout the year.

Reams of paper could be used to enumerate the myriad activities of the Auxiliary this year. Suffice to say, we are concerned, and our influence is being felt from the mountains to the coast of North Carolina.

Mrs. Philip E. Russell (Lu), President

REPORT OF COUNCILORS

FIRST MEDICAL DISTRICT

During 1974, there was a continuing decrease in primary care physicians (general practitioners, family practitioners, general internists). Offsetting this somewhat was a welcomed increase in some specialty areas such as orthopedics and urology. Increasing group practice continues to be a trend in the 1st District.

We were appreciative of the renewal of the University of North Carolina continuing education program, aided by the services of the UNC Medical School "Air Force."

The end of 1974 brought considerable worry to all member physicians in the area of malpractice insurance. This would appear to be one of our greatest problems at this time.

Hospital facilities in the area have been enlarged and others are in the planning stage. Home health services are greatly assisting the physicians in continuing care of many aged and disabled patients.

Finally, the "local" PSRO has been organized and local physician participation seems to be encouraging.

Edward G. Bond, M.D., Councilor

SECOND MEDICAL DISTRICT

The Second District has had a rather quiet year since the last report. The biggest thing in this area is the start-up with the organization of PSRO. Forty percent of the physicians in this area have applied for membership in the PSRO.

We have had a satisfactory influx of physicians into this area since the last report, but we are still quite short in those who are willing to undertake family practice.

The ECU Medical School appears to have gotten a boost upwards since the last report to the gratification of most of the physicians in this area.

J. B. Warren, M.D., Councilor

THIRD MEDICAL DISTRICT

Activity in the Third Medical District over the past year has centered upon compliance with Public Law 92-603, the Professional Standards Review Organization Plan. All county components of the district have been thoroughly briefed in the law's far-reaching stipulations in regard to medical care evaluation, cost effectiveness, and doctor-patient relationships. The PSRO covering this district has been organized and chartered.

The members of the Third Medical District by and large feel it necessary to support this law even though it is believed that little savings in medical cost will be effected by it.

E. Thomas Marshburn, Jr., M.D., Councilor

FOURTH MEDICAL DISTRICT

The Fourth District survived another year in reasonable, if not good shape. (Not much in medicine is in good shape at this point in time.) Some discussions were held among physicians regarding the function, relation and purpose of the various medical districts in the over-all picture of the State Society and it was a little difficult to explain to everyone's satisfaction the role of the District and why it is like it is. A fairly well attended annual meeting was held in Rocky Mount during the fall and several of the state legislators were present as guests of the District to hear a conservative program. Our PSRO is in the formative state and will probably be operational next January.

I attended all Council Meetings.

Harry H. Weathers, M.D., Councilor

FIFTH MEDICAL DISTRICT

Hosted by the Moore County Medical Society, the Fifth District Medical Society held its annual meeting on Oc-

tober 2, 1974 at the Country Club of North Carolina in Pinehurst with Dr. Michael Pishko presiding.

Morning golf preceded and an evening of dining and dancing followed an informative and varied afternoon scientific program presented by Dr. Newton Brackett, Medical University of South Carolina; Dr. William Creasman and Dr. Hilliard Seigler, Duke University School of Medicine and Dr. John Ellis, Pinehurst Surgical Clinic.

During the business session which followed, Dr. Stanley Vetter of Rockingham was elected President; Dr. Hugh McAllister of Lumberton, President-Elect and Dr. Eric Larsen of Pinehurst, Secretary-Treasurer. The Richmond County Medical Society will host the 1975 meeting — time and place to be announced.

The medical affairs of the District went smoothly during the year due to able leadership on the county society level. We are always thankful for the efficient and willing help we receive from the headquarters staff in Raleigh.

Albert Stewart, M.D., Councilor

SIXTH MEDICAL DISTRICT

During this past year the Councilor attended required meetings and responded to members' request for services. There was a general atmosphere of cooperation and progress.

J. Kempton Jones, M.D., Councilor

SEVENTH MEDICAL DISTRICT

The Seventh Medical District enjoyed a harmonious 1974. The Councilor attended several county medical society meetings of component societies in the district but no Seventh District meeting as such was held. Except for one Executive Council meeting the Councilor has represented the Seventh Medical District at all Council meetings, the Committee Conclave, and the annual state convention in Pinehurst. He received copies of correspondence from a component society which was having some trouble with a practitioner and was also appointed to a committee to conduct an investigation of a physician who is not a member of the North Carolina Medical Society.

Jesse Caldwell, M.D., Councilor

EIGHTH MEDICAL DISTRICT

The councilor wishes to report an orderly and productive year for the Eighth District. The component societies of the district have been busily engaged in the formation of PSRO's among their other activities. There have been no specific problems of a significant nature reported to the councilor.

Ernest B. Spangler, M.D., Councilor

NINTH MEDICAL DISTRICT

I have attended two council meetings in 1974 and made one investigation at the request of the State Board of Medical Examiners with reference to the misuse of controlled drugs. This has been reported back to the State Board of Medical Examiners.

No other unusual happenings were reported in this District.

Verne H. Blackwelder, M.D., Councilor

TENTH MEDICAL DISTRICT

The Tenth Medical District enjoyed a satisfactory professional year.

Our most important action was the formal organization of the Western North Carolina Peer Review Foundation. On November 26, Articles of Incorporation were signed and a Board of Directors elected. The Board will be composed of physician representatives of each hospital in the first PSRO Region.

It is anticipated that WNCMPRF, Inc., will be sufficiently organized and in position to apply for Planning Grant Funding from HEW by April 1. Ultimately we will seek designation as a conditional PSRO for this region. The organizational paper work and funding for this activity has been accomplished through administrative leadership provided by the North Carolina Medical Peer Review Foundation. Properly organized and supervised by physicians, this program has the potential of improving quality and possibly diminishing medical care costs of government funded patients.

A Tenth District Social Meeting was held at the Hendersonville Country Club on April 3. Approximately 150 physicians and their wives became much better acquainted as a result of this occasion. The food was excellent and there was no formal program. Tentative arrangements have been made for a 1975 get together, probably in early April.

The progress of AHEC in Asheville and all of Western North Carolina has been a pleasant professional surprise. The monthly scientific seminars and workshops have been of high quality. Much is being done in the field of continuing education, not only for physicians but for nurses as well as medical students and house officers.

In June 1975, construction will be started on an Education Building which will connect Mission and St. Joseph's Hospital and will accommodate a Health Science Library along with a 300 Seat Lecture Hall and much needed office space. Also the Loretta Hall Building at St. Joseph's Hospital will be remodeled into a family medical center.

"Indeed, North Carolina is coming of age."

Kenneth E. Cosgrove, M.D., Councilor

ADMINISTRATION COMMISSION

(Report not received March 20, 1975)

ADVISORY AND STAFF COMMISSION

The activities of the Committees under the Advisory and Study Commission are in the individual reports of these Committees.

The Committee on Relative Value Study submitted a Relative Value Study Index in the late fall but has had the Index referred to several specialty organizations for changes which they deemed necessary.

I would like to express my appreciation to the individual chairmen and the committee members who participated in the activities of the Commission during the past year.

Roy S. Bigham, Jr., M.D., Commissioner

ANNUAL CONVENTION COMMISSION

Committee on Arrangements

A new format for the Annual Sessions was implemented at the 120th Annual Session of the North Carolina Medical Society and was well received.

The 1975 Annual Session will utilize the latter part of the week and it will be held May 1-4, 1975. The North Carolina

Medical Society will join the South Carolina Medical Association to participate in a Continuing Education Caribbean Cruise, May 7-14, 1975.

A survey of the membership was conducted in April, 1974. A response of 37% of the membership elected to continue its meetings in Pinehurst, by a 4 to 1 majority.

Committee on Audio-visual Programs

This committee offered an outstanding program at the 120th Annual Session of the North Carolina Medical Society and plans a program of equal quality for the 121st Annual Session.

Committee on Scientific Awards

The Committee on Scientific Awards is at this time developing a mode of solicitation of scientific papers by the membership. Modes of presentation have been established.

Committee on Credentials

The Committee on Credentials has established a new, less time consuming method of certifying credentials at future Annual Sessions.

Committee for General Sessions Program

A new format for the General Sessions was presented at the 120th Annual Session of the North Carolina Medical Society. Continuing Education Sessions were presented by The Bowman Gray School of Medicine and The University of North Carolina School of Medicine. Both sessions were of excellent quality and were well attended. The socioeconomic session was also well received and well attended.

Committee on Exhibits

At the May, 1974 session of the Executive Council of the North Carolina Medical Society, the name of this committee was changed to the Committee on Exhibits signifying the functions that fall to its charge. These functions are, of course, the supervision of both scientific exhibits and technical exhibits as well as the solicitation of scientific exhibits for the Annual Session.

At the 120th Annual Session of the North Carolina Medical Society awards for excellence were presented to John L. Sawyer, M.D. for his exhibit, REMEDIAL OPERATIONS FOR POSTGASTRECTOMY SYNDROMES and to Kenneth B. Lewis, M.D. for his exhibit, RECHARGEABLE CARDIAC PACEMAKER. Due to the excellent quality of all the scientific exhibits, the judges found themselves in the unhappy position of having to make a choice.

Solicitations of exhibits for the 1975 Session have been made and responses thus far have been excellent.

Josephine E. Newell, M.D., Chairman

PROFESSIONAL SERVICE COMMISSION

The Professional Service Commission can report that the committees in this commission are functioning actively and most satisfactorily. The Insurance Industry Committee has implemented its charge of \$25.00 for each of the cases submitted to it for claims review and has had in addition to a full schedule of cases to review, substantial policy decisions to handle.

The Committee to work with the Industrial Commission has taken steps to upgrade the fixed fee schedule of the Industrial Commission and this should be forthcoming shortly.

The Committee on Blue Shield passed a resolution which would change the structure of the committee and this resolution was presented to and passed by the Executive Council with a minor change.

All of the other committees are functioning satisfactorily and can be expected to continue to do so.

Bernard A. Wansker, M.D., Commissioner

PUBLIC RELATIONS COMMISSION

All of the Committees of the Public Relations Commission met in Southern Pines during the Committee Conclave in September 1974. Several of the committees have met since then. With few exceptions, each of these meetings were well attended and productive as indicated by the reports of the Committee Chairman listed separately. Some of the activities of the committees are outlined below:

Medical Legal Committee — Julius A. Howell, M.D., Chairman

1. A survey questionnaire follow-up is being made to evaluate the medical care services rendered in county jails.
2. Recommendations as to how to avoid malpractice suits were sent to members of the North Carolina Medical Society.
3. Plans were made for a joint meeting with the medico-legal committee of the North Carolina Bar Association.

Eye Care and Eye Bank Committee — Ernest W. Larkin, Jr., M.D., Chairman

1. Methods were recommended to improve the services for medicaid patients.
2. Present methods for retrieval of donated eyes were reviewed and updated recommendations made.
3. Recommendations to improve services provided in Blind Clinics were made.
4. Assistance was given to the N.C. Department of Motor Vehicles in setting of new visual standards for drivers of motor vehicles.

Committee Liaison to the North Carolina Pharmaceutical Association — Charles W. Byrd, M.D., Chairman

1. The list of physicians dispensing medications under medicaid was reviewed.
2. A liaison committee was set up to study medications in emergency medical kits in institutions of long term care and prepare recommendations.

Committee on Disaster and Emergency Medical Care — George A. Watson, M.D., Chairman

1. A statement of support for the Emergency Medical Services program underway was made that was received favorably by the Executive Council.
2. Methods to improve physician coverage in Emergency Rooms were suggested.

Committee on Association of Professions — Thomas G. Thurston, M.D., Chairman

1. Happenings of joint professions concern were reviewed by the Committee and recommendations made as to how we can more effectively work together.
2. Support behind the proposed new veterinary school was given.

Committee on Legislation — H. David Bruton, M.D., Chairman

1. Continuing surveillance was provided state and national health legislation and reported to the Executive Council.
2. Plans were made for a Legislative Workshop to be held in the Center for Continuing Education September 1975 in Boone.
3. Arrangements were made for a Reception for members of the 1975 General Assembly to be held in Raleigh on April 8, 1975.
4. An excellent position paper was prepared by the Committee on where organized medicine stands on certain issues.

Committee on Community Medical Care — J. Kempton Jones, M.D., Chairman

1. Support was given for legislative refunding of the Community Preceptorship Program at Bowman Gray School of Medicine with opportunity of expansion to other medical schools.
2. The importance of the goal that at least 50% of the graduates of medical school enter primary care was presented at a joint meeting of the Committee on Higher Education of the N.C. State Legislature.

Committee on Public Relations — John L. McCain, M.D., Chairman

1. A position paper on the Public Relations Program of the NCMS was prepared and accepted by the Executive Council.
2. A Conference for Medical Leadership was sponsored on the topic of Problems in Medical Practice at the Headquarters Office Building in Raleigh.

For detailed accounts of committee actions and deliberations please refer to the respective committee chairman's report.

I would like to commend the committee chairmen and the headquarters staff for the excellent service performed; the leadership given and the accomplishments achieved in the Public Relations Commission.

John L. McCain, M.D., Commissioner

PUBLIC SERVICE COMMISSION

One of the most outstanding factors in the work of the various committees in the Public Service Commission in 1974 has been the dedication of the committee members and their chairmen. I was tremendously impressed during the September conclave as I recognized the type of doctors we have working with us on these committees. I would suspect that the Society's greatest asset is the unstinted cooperation of very highly qualified members of these committees.

The Committee on Child Health and Infectious Diseases considered the Comprehensive Health Screening Program for four year olds in North Carolina. It was pointed out that the proposed bill would be introduced in the 1974 legislature and it was expected that close to nine million dollars would be asked for the first two years of the program. It was agreed that the progress of this legislation would be carefully followed. It was felt that there was no need to suggest changes in immunization procedures for the coming year but "Immunization Action Month" was discussed and it was decided to request that activities along

these lines be included in the President's Newsletter and the Public Relations Bulletin. The progress of the regionalization of prenatal care was also discussed. It was pointed out that the regionalization committee had been set up and had held one meeting. It consists of ten members with Dr. John Ash serving as chairman. The committee is still in the planning stages and whatever program is implemented will be a voluntary one.

The committee expressed some concern over its recommendations made to the Executive Council at the last meeting on September 26, 1973. It had urged the adoption of the resolution to consider the use of prophylactic isoniazid. The Executive Council had apparently turned down the resolution because it had felt there was still some controversy concerning INH. It was agreed that the commissioner would request that each and every member of every committee be sent an advisory on what recommendations were taken by the Executive Council at this meeting. The chairman of the committee was sent a summary of the actions of the Executive Council. It did approve a recommendation from the committee for the approval for the use of prophylactic treatment of tuberculosis in North Carolina so as to conform with the standards of the Center for Disease Control of the U.S. Public Health Department. The committee also recommended to the Medical Society that the Red Cross devise means of its own choosing to properly refer hypertensives to suitable authority. The Executive Council approved of this action.

There was much discussion in the September meeting on utilization review procedures for community mental health centers. The Division of Mental Health had applied to the National Institute of Mental Health for a grant to review the work of the new model mental health centers being established in the state. The committee made the following recommendations:

"The committee recommends that the chairman appoint two representatives of the Mental Health Committee or of the Medical Society to advocate, based on their own experience, the high quality of care which we feel should be applicable in both private and public psychiatric care, and that these representatives of the Medical Society be designated to serve with those seeking to make a grant application entitled: "PSRO Model — Utilization Review Procedures for Community Mental Health Centers," in its planning phase. We feel that it is essential that the North Carolina Medical Society should be actively, realistically and vitally involved in the establishment and continued guidance of such a project. The Executive Council took positive action on this recommendation.

The Committee also recommended that the Medical Society take notice of what it regarded as one of the many unconstitutional points in the commitment law and a sentence in it which stated that all patients being committed must be referred to the mental health system should be changed so that there not be infringement on the private practice of psychiatry. The council voted that the principle be accepted and referred the matter to the legislative committee to work out in conjunction with the committee on Mental Health.

A letter was received by the chairman from Dr. Rollins, President of the North Carolina Association of Family and Marriage Counselors, pertaining to a bill suggesting the licensing of marriage counselors in the state. The matter was referred to the Committee on Family and Marriage Counseling.

The Committee had the opportunity to hear from Dr.

Fred Patterson who represented the Motor Vehicles Department. He visited us to seek our advice and also to give us some information concerning the Department's problems in medically evaluating people as far as their ability to drive an automobile is concerned. He showed us a letter which has been prepared with the help of Dr. John Ewing and which is sent to drivers who have been having alcohol and driving problems. The letter included the self-evaluation test and also gives the driver indications as to where help is available.

The Committee also recommended to the Executive Council that the encouragement be given to promote a large Governor's Conference on Alcoholism. The Executive Council did back such a conference and the Medical Society was a co-sponsor. The major force behind the conference and the alcoholism awareness week was the North Carolina Alcoholism Research Authority of which one of our members, Dr. John Ewing, is the Executive Director and which the Chairman of the Mental Health Committee is Vice-Chairman.

The Committee proposed and the Executive Council approved of a recommendation that the Medical Society support the surcharge on beer and wine to help support the North Carolina Alcoholism Research Authority.

The work of the Nurse-Psychiatric Task Force was discussed. The Medical Society and the State Nurses Association jointly appointed a subcommittee of the Joint Practice Committee as a task force on psychiatric mental health services. It is hoped that the work of this task force will be completed early in 1975 and its proposals submitted to the Executive Council.

Notation was also made of the Southeastern Regional Conference of Mental Health Representatives of the American Medical Association which was held in Atlanta in April, 1974 and which received the whole hearted backing of the committee as well as the North Carolina Medical Society.

The Committee on Drug Abuse met in intensive discussion during the September conclave and explored the drug problem in North Carolina. Mr. S. E. Epps, Director of the North Carolina Drug Authority, participated actively in this discussion and brought the committee up to date on recent state developments. Part of the resolution sent to the Executive Council stated: "It is an act of charity to report a fellow M.D. for suspected drug abuse to the North Carolina Board of Medical Examiners. Not doing this is to wish your fellow M.D. to further self-destruction and failure to provide quality care for his patients." The resolution was approved by the Executive Council. The committee also recommended to the Executive Council that it go on record: (1) As approving new legislation which would enable physicians to give verbal orders for other than controlled substances to pharmacies and, (2) recommend that the Medical Society through its news media review prescribing practices for both controlled and uncontrolled substances for the benefit of the membership".

The Committee on Marriage Counseling and Family Life Education noted that a very successful meeting in honor of Mrs. Ethel Nash had been held in May, 1974 and it was felt that the quality of the presentation of the meeting did her honor.

It was also recommended that there be a one day meeting in April, 1975 in which the treatment of sexual problems would be discussed. Later it was decided in view of the considerable activity by others in this field at this particular time that this committee would not sponsor such a program.

A bill entitled "Marriage and Family Counseling Model Bill" which it was expected would be presented to the General Assembly was discussed. It would require licensure of certain individuals who carry on the practice of marriage and family counseling in the state of North Carolina.

It was brought out by the Chairman that medical students and their wives have expressed to him the feeling that there should be some kind of service in the medical schools which would be available to students and their wives during the student's training and that, where so desired, opportunities for marriage evaluations and marriage counseling should be available to the students. It was the consensus of the committee that the medical school should be contacted about this matter and an attempt will be made at the next year's meeting to pursue it further.

The Committee on Occupational and Environmental Health had an extremely busy meeting in September. It recommended that the North Carolina Medical Society provide the widest possible dissemination of information on occupational health and safety items through publications to its membership. It also urged that a program be presented on recognition of common occupational hazards in North Carolina at the State Medical Society meeting in 1976. In addition it urged that the State Medical Society sponsor a group of resource physicians of the Society to be available to interested groups or county medical societies as speakers for explaining specific hazards and their consequences. In addition it recommended that the North Carolina Medical Society act as a co-sponsor for the program on Occupational Medicine to be presented by Dr. Leonard Goldwater at Duke University on February 7 and 8, 1975. It also expressed the hope that the Medical Society would co-sponsor other such programs. This series of recommendations designed to make physicians in North Carolina more fully aware of the common hazards in the working environment of their patients and generally to promote the society providing the widest possible dissemination of information on occupational health and safety items was approved by the Executive Council.

Philip G. Nelson, M.D., Commissioner

DEVELOPING GOVERNMENT HEALTH PROGRAMS COMMISSION

(Report not received March 20, 1975)

REPORT ON COMMITTEES

COMMITTEE ON ALLIED HEALTH PROFESSIONALS

The Committee on Allied Health Professionals met at Southern Pines, North Carolina on September 27, 1974. The critical shortage of clinical nurses in the hospital setting was discussed at length. Mr. Crenshaw Thompson,

Administrator of Moore Memorial Hospital enumerated the problems and possible solutions were explored.

The impact of recent legislation on nursing practice in North Carolina was discussed. Registered nurses, performing medical acts in the Family Nurse Practitioner setting, are being considered and approved by a joint subcommittee of the Board of Medical Examiners and the

COMPILATION OF ANNUAL REPORTS

State Board of Nursing. At this time, only applications in the Family Nurse Practitioner setting are being considered, but in the future other groups, such as nurses performing medical acts in the hospital setting, will be considered.

The continuing activities of the Joint Practice Committee of Medicine and Nursing were discussed. The following motion was passed: **THIS COMMITTEE RECOMMENDS TO THE EXECUTIVE COUNCIL THAT THE JOINT PRACTICE COMMITTEE CONTINUE TO BE UNDER THE AUSPICES OF THE NORTH CAROLINA MEDICAL SOCIETY, AND THAT THE REPRESENTATIVES FROM THE NORTH CAROLINA MEDICAL SOCIETY BE APPOINTED ANNUALLY, ALWAYS INCLUDING THE CHAIRMAN OF THE COMMITTEE ON ALLIED HEALTH PROFESSIONALS.**

Decision was reached to submit a letter of formal invitation to the Organization of Physicians' Assistants inviting them to attend the Scientific Sessions of the Meeting of the North Carolina Medical Society in May, 1975.

W. Benson McCutcheon, Jr., Chairman

COMMITTEE ON ANESTHESIA STUDY

At the Committee Conclave in Southern Pines, Chairman of the Anesthesia Study Committee, Dr. Bechtoldt, reported on the success of the Medical Examiner system. In an analysis of questionable operating room deaths in 1973, the Medical Examiner was involved in 80% of them, and nearly doubled the number of questionable operating room deaths reported to the committee. In addition, the response to questionnaires where the Medical Examiner was involved was much greater than those reported by the death certificate. However, since there was still a significant number of operating room deaths not reported by the Medical Examiner plus a few anesthetic related deaths not occurring in the operating room, it was felt that data should still be collected by the death certificate system as well.

To emphasize the Medical Examiner system, an article entitled, "Operative Deaths," appeared in the Public Relations Bulletin in April 1974. In this article, Dr. Page Hudson, Chief Medical Examiner, discussed the new law. He commented that he considered that the deaths in question would be those that occurred in the operating room or recovery room, where there was some reasonable question of accident or misadventure. In a separate communication, he defined the operating room as "any area in the hospital where anesthesia is given and/or where surgery is performed."

Dr. H. A. Ferrari, Chairman of the Department of Anesthesiology at Charlotte Memorial Hospital, was invited to join the Anesthesia Study Committee, and has accepted.

Also discussed at the Committee Conclave were individual anesthesia related case reports.

Albert A. Bechtoldt, Jr., M.D., Chairman

COMMITTEE ON ARRANGEMENTS

The Committee met in Southern Pines on September 26, 1974, with good attendance.

The May 1974 meeting was reviewed, and particular note was made of the unusually good attendance at the general sessions. The plans for the 1975 annual meeting were reviewed. Time and place of future meetings was discussed. The desire of the membership for continuation in Pinehurst was noted, but other potential sites were reviewed. It was

noted that the cost of these newer sites is considerably less than we are currently expending.

Because of overlap of activities, the Committee recommended that the Committee on Medical Education be assigned to the Annual Convention Commission, and that the committees on arrangements, general sessions, and medical education be combined into one committee to be named the Convention Arrangements Committee.

These recommendations are to be carried to the Executive Council by Commissioner Newell.

E. Harvey Estes, Jr., M.D., Chairman

COMMITTEE ON ASSOCIATION OF PROFESSIONS

The North Carolina Association of Professions continues to build its force and effectiveness across professional service lines in our state. Its leadership has meshed with the leadership of its member groups — for better communication; better joint actions; and a closer understanding of the dependent relationship, one for the other. It has been an active year for its officers and its board, in finding ways to better serve its members. The most outstanding event for the year was an indepth workshop held October 30-31 at the Governor's Inn, Research Triangle Park, with Hugh W. Brennaman of Michigan, as its leader.

A plan of action was identified in some ten commitments, which will strengthen the public affairs projects for the next two to five years. These commitments have been publicized to each member group as a means of building better relationships with the involved groups.

Communications was the key theme of the October workshop, and the recommendations are being set into motion for 1975. Task forces will be working and reporting their recommendations to further carry out the commitments made last fall.

The Theme of the 1975 Annual Meeting stemmed from the workshop "How to Prepare for Emergencies and Crises" focused on the wife and family of the practitioner who is disabled or dies suddenly. Preparing for Retirement is another target area, with a task force assigned to work out program details. Public affairs, legislative information, added insurance protection for members are other areas of assignment for the coming year.

Public recognition of "public service" by individuals to their profession and community continues to rank as a top priority for the Associations Awards. During the year the Association has communicated many times with top authorities about two of its 1973-1974 priorities:

1. support for a Veterinary School of Medicine at N. C. State University
2. support of the professional licensing boards — to maintain their independence to more effectively protect the public from unqualified, irresponsible practitioners and/or non-legal practices

Both of these priorities have been voiced repeatedly the past two years and its leaders are encouraged by the response received. Continued emphasis is being placed on the lead and support roles of the Association on behalf of its members.

Officers for the past year have been: President: A. W. Smith, DVM of Farmville; 1st Vice-President: B. Cade Brooks, Rph. of Fayetteville; 2nd Vice-President: John L. Thompson, D.D.S. of Shelby; Secretary: Thomas G. Thurston, M.D. of Salisbury; and Treasurer: Bosworth Beckwith, A.I.A. of Raleigh.

The Annual Meeting of the Association will be held March 6th in Raleigh at the Velvet Cloak Inn. The leaders

of the House of Representatives and of the Senate will address the luncheon session and members of the General Assembly will be entertained with a Social Hour at the close of the afternoon educational seminar.

The Association's program has been guided by able officers and its Board of Directors over the past decade, and the next few years promise unified efforts to produce beneficial accomplishments for its members.

Thomas G. Thurston, M.D., Chairman

COMMITTEE ON AUDIO-VISUAL PROGRAMS

The Committee on Audio-Visual Programs met during the Committee Conclave in September 1974.

An interesting program has been planned for the Annual Meeting in May from 9:00 a.m. to 5:00 p.m. on Thursday, May 1st and Friday May 2nd. Members of the Committee will serve as Moderator at each Session.

The full program of films will be distributed to the membership in the April issue of the Public Relations Bulletin and also listed in the official program copy.

A special invitation is extended to members of the Auxiliary to attend any portion or all of the Audio-Visual Program.

This program is accredited by the AAFP for twelve (12) hours.

G. P. Henderson, Jr., M.D., Chairman

COMMITTEE ADVISORY TO THE AUXILIARY

The Committee Advisory to the Auxiliary met in Pinehurst on September 25, 1974 with all but one of the committee members in attendance. Prior to 1973 this committee was known as the Committee Advisory to the Auxiliary and Archives of History and from 1973-1974 the committee was made part of the committee on AMA-ERF. In September, 1973 at the suggestion of the officers of the Auxiliary, Dr. Roy Bigham, Jr. recommended to the Council on Review and Development that a new committee, the Committee Advisory to the Auxiliary be established. This committee will now be responsible for the AMA-ERF program.

At the September meeting, a special recognition was given to Dr. Roscoe McMillan and his Committee on Archives of History for their work in preparing *The History of Medicine in North Carolina*. A resolution was passed that a letter be sent to Dr. McMillan, Dr. Wiley Forbus, Dr. W. Reece Berryhill, Dr. John S. Rhodes and Dr. Warner Wells for the fine work that each of these men carried out on the two volume history, a work all of us are proud of.

Mrs. Elliott Dixon was recognized for her capable guidance of the Auxiliary during 1973-1974. The special focus during her tenure as President was — AMA-ERF, health manpower, safety, nutrition, blood banks and legislation.

Mrs. Phillip E. Russell, Auxiliary President for 1974-1975 discussed the Auxiliary theme for the year which is communication, cooperation and education. There are now 2,813 members of the Auxiliary. Dues have been increased to \$4.00. The budget is approximately \$16,000.00 of which \$5,400.00 is received from the Medical Society. There are 48 auxiliaries in 64 counties. Total registration for the two Fall Workshops was 169, the largest in the history of these workshops. During the previous year a total of \$18,400.00 was contributed to AMA-ERF in North Carolina, a 68.8% gain.

Outstanding loans in the Student Loan Program now total \$28,059.00. One third of that, \$9,900.00, was loaned during the past year and the cash balance now is \$7,627.00. Four sanatoria beds are completely endowed with assets of \$42,000.00. Interest from this investment not used for patients in these beds is added to the Student Loan Fund. The Mental Health Research Endowment Fund has \$20,700.00. The interest of \$1,277.69 has been given to the Department of Psychiatry at the University of North Carolina in Chapel Hill.

The main emphases for this year, as discussed by Mrs. Russell, are membership, especially to encourage small auxiliaries to combine into one and active auxiliaries to take members at large and faltering auxiliaries into their auxiliary, AMA-ERF, legislation utilizing "Legsline" — a letter writing network to keep the legislators informed of our concerns, AMPAC-MEDPAC whose present membership stands at 230. Health education is to be stressed, especially improving and augmenting the health education in the schools and improving the qualification of the teachers of health courses. Family health is to be emphasized, especially drugs, alcohol, child abuse and testing and screening for learning disabilities. Community health is another area of concern and quality day care centers for children and nursing homes for the elderly are to be encouraged. Other important areas of community health are immunization for preschoolers and talking books for the handicapped.

Mrs. William Corpening, Auxiliary Chairman for AMA-ERF reported that the Auxiliary has cookbooks and Christmas cards for sale with the proceeds going to AMA-ERF. Contributions can be made to AMA-ERF in "honor" or "memoriam" of another and cards are available for recognition of these gifts. It was decided that two mailings would be sent from the Raleigh office regarding AMA-ERF. One of these was sent to all physicians in December. We are grateful to Dr. Frank Reynolds who was present at our meeting and consented to mention AMA-ERF in the President's Newsletter. This was done during the fall. The Auxiliary is requesting that physicians channel their contribution to AMA-ERF through their county auxiliaries so that the state auxiliary and local auxiliary will get credit for these contributions. The contributions may be designated for one particular school in North Carolina or they may be undesignated and go into a general fund to be divided among the four-year medical schools in the United States. Loan Guarantee Program contributions may not be designated for a particular school but for each dollar given in this fund another \$12.50 is added.

As these loans are repayed by students, this money is again reactivated to help more medical students finance their education. Each committee member was given an excellent informational booklet prepared by Mrs. Joe W. Frazier, Jr. on AMA-ERF and various projects which may be carried out to raise money for this most worthwhile program. The "Tar Heel Tandem" and its need for additional funds was discussed. The increased cost of printing has made their original budget request inadequate. A motion was made that the Committee Advisory to the Auxiliary request the Finance Committee for \$500.00 for additional funds for the "Tar Heel Tandem" This was done and the Finance Committee very generously gave the additional, much needed money. It was also decided that during the next year that the chairman would request funds for AMA-ERF in the budget. Mr. Hilliard kindly consented to let us have access to envelopes at the Headquarters office for the two AMA-ERF mailings during this year.

The History of Medicine in North Carolina was discussed.

Mr. Hilliard stated that 600 copies had been sold. It was suggested that the history be reviewed in the "Tar Heel Tandem" and perhaps in the State Magazine or any other appropriate publications.

The committee is most appreciative of the help and interest shown by Dr. Frank R. Reynolds, President, Dr. James E. Davis, President-Elect, Dr. George Gilbert, Past President, Dr. Roy S. Bigham, Commissioner, Mr. William N. Hilliard, Executive Director of the North Carolina Medical Society and Mrs. Jackie Cutrell, Staff Member and secretary assigned to the Auxiliary.

I am most appreciative of the excellent work carried out by the Auxiliary. It is a pleasure and a privilege to be associated with such an outstanding group.

Gloria F. Graham, M.D., Chairman

COMMITTEE ON SCIENTIFIC AWARDS

Following the annual meeting of the North Carolina Medical Society in May 1974 the scientific papers selected by the various specialty organizations were received and distributed to members of the Committee on Scientific Awards. On September 27, 1974, the Committee met at Mid Pines and made the following selections for awards:

"Pediatric Urological Roentgenology" by Herman Grossman, M.D. for the Moore County Award
 "Urinary Tract Infections in Children" by William G. Conley, III, M. D. for the Wake County Award.

The Committee accepted the following guidelines for a new award, the "Durham-Orange County Medical Society Award" as follows:

"The Committee on Scientific Awards of the North Carolina Medical Society is pleased to announce the establishment of the Durham-Orange County Medical Society Award for the best scientific paper submitted each year by a medical student or house officer. Durham-Orange County Medical Society has made possible this competition to encourage participation by medical students and house officers in the affairs of the North Carolina Medical Society. A certificate and cash award of \$250 will be presented each year to the author or principal author of the most meritorious paper which is submitted prior to January 15th of that year to the Chairman of the Committee on Scientific Awards. Papers may deal with any subject of potential interest and value to a physician and, eligibility for the award is open to any medical student, intern or resident who at the time of submission of the manuscript is enrolled in a medical school or serving as a house officer in the state. The paper shall not have been published previously.

The Committee on Scientific Awards will select the winning paper prior to the Annual Meeting of the North Carolina Medical Society where it will be presented by title or in its entirety. No award will be made in a given year if in the opinion of the Committee on Scientific Awards no deserving paper was submitted."

The Committee expressed its appreciation to the Durham-Orange County Medical Society for making this award possible.

David S. Citron, M.D., Chairman

COMMITTEE ON BLUE SHIELD

The Blue Shield Committee held five scheduled meetings during the past year with good attendance by Committee members and other Medical Society officials. These meeting dates were established in advance; and the entire

Society membership was notified of the meeting schedule through bulletin by the Headquarters Office and informed that any member could present matters for Committee consideration. In addition, the Claims Review Subcommittee met ten times, and there were several called meetings of Ad Hoc Committees appointed to consider special issues.

By action of the House of Delegates at the May 1974 annual meeting, separate sections for ophthalmology and otolaryngology were made effective, and neurosurgery as a separate section was added. This increased the membership of the Committee from 28 to 32 members.

Dr. John W. Foust was duly appointed to represent otolaryngology; Dr. George T. Thornhill to represent ophthalmology; Dr. Robert L. Timmons to represent neurosurgery; and Dr. David L. Kelly, Jr. to represent neurosurgery. Dr. Franklin E. Altany was appointed as a plastic surgery consultant.

During last year's meetings a variety of subjects were discussed, actions taken, and reports given. Specialty members acted in a liaison capacity between the Committee and specialty groups to help resolve problems involving new or unusual services. Among many matters involving problems or special consideration were policy changes for rhinoplasty allowances, administration of obstetrical anesthesia by the delivering physician, medical services by physician employed nurse or physician assistant, the reasonable basis for reimbursement for laboratory tests, special anesthesia monitoring, and the use of cardiology diagnostic tools such as echocardiograms. The meetings of the full Committee were characterized by meaningful dialogues between the Committee and Blue Cross and Blue Shield of North Carolina, with questions relating to these discussion.

The correlation of the opinions, advice, and decisions of this and previous Blue Shield Committees has kept the formal activity of the Committee to a bearable level. Committee actions continue to contribute to Blue Shield policy decisions and maintain effective communications between the Corporation and the Medical Society.

Serving on the Claims Review Subcommittee were Doctors Robertson, McCutcheon, Vatz, McBryde, Monroe, and Williams. Other members of the Committee and consultants have met with the Subcommittee several times to advise on specific problem areas or for orientation in claims review. During the ten meetings approximately 225 cases were formally adjudicated. Issues from which important precedents, schedule modifications, and general guidelines relating to charges and the customary medical practices emerged and were referred to the full Committee for final approval. Claims were reviewed at the request of the individual physician, Blue Shield subscriber, or the Corporation when there was a question about the type and amount of benefits applicable or when a procedure or service was provided for which benefits had not been established. Subcommittee members have frequently consulted Committee consultants and specialists on an advisory basis when specialized knowledge was needed.

Committee members and consultants have given generously of their time serving as advisors in problems relating to their specialty. There have been approximately 1200 communications with the Corporation about customary medical care and Blue Shield professional benefits.

In response to Dr. David S. Johnston's recommendations in his annual report as Chairman last year and Commissioner Bernard A. Wansker's recommendations on Committee structure and tenure, the Committee in their December 5, 1974 meeting agreed upon the following recommendations to the Executive Council:

"With the approval of the Executive Council, the President shall appoint the members of the Committee on Blue Shield. The term of appointment shall be one year, subject to reappointment annually for no more than four additional terms, contiguous or not. After the maximum number of terms have been served, no member may again be appointed until three consecutive years have elapsed. The President shall appoint at least one member from each specialty and as many more as are necessary for the proper functioning of the Committee. He shall consult with the specialty sections regarding the choices that he wishes and he shall endeavor to ensure as wide a geographic and specialty representation as possible."

Dr. Bernard A. Wansker has attended all Claims Adjudication Meetings and has been most helpful in establishing better communications with physicians and in the improvement of the Claims Review function.

Blue Cross and Blue Shield of North Carolina has been cooperative and responsive at all times and the Committee is grateful for the active support of Committee functions by Mr. Thomas A. Rose, President, and physician members of the Board of Trustees; and to Mr. K. G. Beeston, Vice President of Blue Shield Activities, for his continued help in the capacity of Secretary and staff support.

The Committee is appreciative of the interest, participation, and frequent meeting attendance of Dr. Frank R. Reynolds, President; Dr. James E. Davis, President-Elect; Dr. George Gilbert, Past President; Dr. Bernard A. Wansker, Commissioner; and William N. Hilliard, Executive Director of the North Carolina Medical Society.

Leon W. Robertson, M.D., Chairman

REPORT OF PHYSICIAN TRUSTEES BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

TO NORTH CAROLINA MEDICAL SOCIETY

1974 saw several major benefit changes in the Blue Cross and Blue Shield program. In a public opinion survey held in the fall of 1973, most North Carolinians held as a priority comprehensive health care coverage and major medical benefits. As a result of this survey and with approval of the Insurance Commissioner, Blue Cross and Blue Shield has instituted a \$250,000 Catastrophic Major Medical program to be offered in early 1975. This coverage is in addition to the basic coverage and features a disappearing coinsurance.

Another addition was a Medicare supplemental certificate for disabled persons identical to the Blue Cross and Blue Shield supplemental coverage for Medicare recipients over 65. Coverage was extended to provide continuing benefits for unmarried mentally retarded or physically handicapped children beyond their 19th birthday.

The waiting period for pre-existing conditions was reduced from 24 to 12 months, effective for services incurred on or after August 13, 1974.

Because of improved computer capacity, the Plan began issuing benefit payments twice a week and has considerably shortened the time lapse between submission of claim and payment. Issuance of benefit checks on a daily basis is planned in early 1975.

A Telecommunications System, initiated in two district offices as a pilot project, was expanded to include all 11 district offices by early 1975. The system's visual display units, connected to the membership files and claims history files stored in the Service Center computers, enable over 80 per cent of subscribers to receive immediate local information about their membership and claim status.

During the year the Plan processed 2.8 million payments for Blue Cross and Blue Shield claims. A record dollar benefit of \$189 million was paid in claims for our subscribers. Total benefits paid through all underwritten and administered programs were \$369 million.

A booklet explaining the UCR concept of providing professional benefits was developed by the Plan for M.D.'s in cooperation with the North Carolina Medical Society's Blue Shield Committee. This was mailed to all North Carolina medical doctors in July 1974.

The Professional Relations Department of the Blue Shield Activities Division added a seventh Professional Relations representative. This change enabled the Plan to provide more adequately for liaison with North Carolina physicians. Planning for 1975 includes adding an eighth representative. The Board of Trustees voted unanimously to hire a full time Medical Director for the Plan, and search is presently underway to fill this position.

Regular Board meetings were held monthly with excellent attendance by all Board members. The spirit of cooperation among management, public trustees, hospital administration trustees, and physician trustees could not have been better. In the fast changing social economic climate of health care delivery many new problems are constantly arising. The Board of Trustees has conscientiously tried to meet each of these new problems and act only after full discussion by all trustees. It is felt that the physician trustees with the representatives from the Blue Shield Committee have had excellent cooperation from management as well as other trustees.

Frederick A. Blount, M.D., Roy S. Bigham, M.D.

James E. Davis, M.D., H. Fleming Fuller, M.D.

Alfred T. Hamilton, M.D., Marvin N. Lymberis, M.D.

Joseph B. Stevens, M.D., Kenneth D. Weeks, M.D.

COMMITTEE ON CANCER

The Cancer Committee met September 25, 1974 at Mid-Pines Club. Representatives from N.C. Medical Society, Division of Health Services of N.C. Department of Human Resources, American Cancer Society, and headquarters staff were present.

A report of the Cancer Tumor Registry was given by Dr. J. A. Buckwalter stating that 23 hospitals are participating in the N.C. Central Registry with a total of 30,000 cases having been assessed. The number one primary site in North Carolina is lung cancer. The Fourth Annual Cancer Symposium will be held in Spring of 1975. A motion was made that an attempt be made to solicit more hospitals to participate in the Central Cancer Registry.

A report from Division of Health Services, N.C. Department of Human Resources, stated that in 1973 approximately 44% of women over 20 years of age in N.C. received Pap Smears. The 3 day Diagnostic and 15 day Treatment program sponsored by the State Health Division has the participation of 82 hospitals in the state.

A study is being conducted to determine possibility of including chemotherapy in the Division of Health Services cancer program. The committee approved the addition of Wilms tumor to diseases for which treatments are funded under the Division of Health Services.

The American Cancer Society, N.C. Division, reported that the Cancer Institution in Lumberton is remaining 98% occupied and continues to give a valuable service. The educational program of the Cancer Society was strongly emphasized both for professional and public education.

The Cancer Committee approved the requests from four N.C. hospitals for participation in the cancer diagnosis and

treatment program. They are Fletcher Hospital, Fletcher, Lawrence Hospital, Mooresville, Person County, Roxboro and Maria Parham Hospital, Henderson.

The Breast Cancer Detection Program at Duke Comprehensive Cancer Center was discussed by Dr. Simmons Patterson. The Cancer Center involved.

- (1) Basic Cancer Research
- (2) Clinical Cancer Research
- (3) Radiological Aspects
- (4) Outreach program

This program has created widespread interest in the State in both professional and lay groups.

Rose Pully, M.D., Chairman

COMMITTEE ON CHILD HEALTH AND INFECTIOUS DISEASE

The Committee met in Pinehurst on September 27, 1974.

Dr. Archie Johnson reported on the proposed Comprehensive Health Screening Program that is being developed by the Department of Human Resources. It is anticipated that a Bill will be introduced into the 1975 Legislature requiring mandatory screening of all four year olds in North Carolina. Committees have been appointed that will study the methods to be used in screening, the personnel needed to be trained to accomplish the screening, and where the testing would be done. The progress of the Program will be followed by the Committee on Child Health and Infectious Disease.

"Immunization Action Month" has been designated as October 1974 and discussion was held of the methods to be used in publicizing this Program. Reports will be included in the President's News Letter, the Public Relations Bulletin of the Medical Society and a committee has been appointed that will provide physician participation for all television stations across the state so that personal appearances can be made on discussion programs.

Dr. Newton McCormick reported on the Rubella HI screening program of the State Health Department. A Colorado law requiring such screening as a requisite for marriage licensure was discussed. The Committee felt that no action need be taken at the present time.

A report on the Regionalization of Perinatal Care was presented and it was emphasized that this was a voluntary program.

On January 30, 1975, a conference telephone call was held between Drs. Blount, Chamberlin, Edwards, Henson, Johnson, Kelly, Roddey, Scurletis and London and during this call unanimous approval was given to a Bill entitled "An Act to Authorize Health Care Services to Minors". A copy of the proposed Bill and notice of endorsement by the Committee on Child Health and Infectious Diseases was transmitted to the Committee on Legislation.

William L. London, M.D., Chairman

COMMITTEE ON CHRONIC ILLNESS, TB, AND HEART DISEASE

The Committee on Chronic Illness met on September 25, 1974 at the Annual Conclave of Committees in Southern Pines, North Carolina.

As the suggestion had been made that the Chronic Illness Committee should evaluate the need for action by the North Carolina Medical Society related to the various programs dealing with hypertension, it was decided to include in this meeting two presentations about this subject.

- I. Dr. Sylvester Valla, Medical Consultant for the Chronic Disease Section of the Division of Health

Services, reported on the findings regarding the incidence of hypertension found in the Screening Clinics held under his supervision.

- II. A presentation was made by Dr. Inez W. Elrod, Medical Director of Piedmont North Carolina Red Cross Blood Center. The Screening of blood donors provides a wealth of information about blood pressure readings in a population group ranging between approximately 18 and 65 and representing all walks of life. The question did arise in what fashion the medical profession could best benefit from the information obtained by the Red Cross Blood Centers. The Committee made the following recommendation:

THE COMMITTEE ON CHRONIC ILLNESS
RECOMMENDS TO THE STATE MEDICAL
SOCIETY THAT THE RED CROSS DEVISE
MEANS OF ITS OWN CHOOSING TO PRO-
PERLY REFER HYPERTENSIVES TO
SUITABLE AUTHORITY.

(UNANIMOUSLY CARRIED)

- III. Dr. A. L. Van Horn, Research Assistant, Department of Hospital Administration, UNC, reported on a study of the appropriateness of patient assignment in hospitals and long-term facilities. This study is appropriate in determining, for future planning, the need for medical facilities and the provision of beds in the proper classification regarding the needed level of care. Although the study is still in its preliminary stage and certainly should include institutions at various levels, certain conclusions appear to be well documented. Twenty-five per cent of the 2100 patients were in the age group of 65 and over. Of these 2100 patients 52.3% apparently were in the proper setting and at the proper level of care; 25% should either have been in another setting within the hospital either in an extended care facility, in a rehabilitation unit, or in a self-care unit. Eight per cent of the 2100 patients should have been in another institution, 2.8% in skilled nursing facilities, 2.4% in intermediate care facilities, 1.2% should have been in some form of protective living. There were an additional 6.8% who did not need to be in an institution and could have been in a home care program. Nearly 20% of the patients should not have been in the hospital any longer.

- IV. Dr. Roy V. Berry, Chief of the Tuberculosis Control Branch of the Division of Health Services, gave a followup report on prophylactic use of Isoniazid in the prevention of tuberculosis. Dr. Berry said the crux of the matter in question was the association of hepatitis with the use of Isoniazid. Dr. Berry said that in 1967 the Committee submitted a resolution to the Executive Council which received the endorsement of the Medical Society. He pointed out that in 1972 and 1973 this committee felt it should be more specific in the recommendations than in 1967 and so the wording was changed. The recommendation submitted was not accepted by the Executive Council. Dr. Berry said that a third draft is following the recommendation of the Center for Disease Control in Atlanta. He said this third recommendation was more restrictive than the original recommendation with one of the key factors being the question of age. He said that the Center for Disease Control based their recommendations on the fact that the frequency of pro-

gressive liver damage is increasing with age. He added that it was rare in individuals under 20. The Committee approved the following recommendation:

THE COMMITTEE ON CHRONIC ILLNESS APPROVES THE USE OF PROPHYLACTIC TREATMENT OF TUBERCULOSIS IN N.C. TO CONFORM WITH THE STANDARDS OF THE CENTER FOR DISEASE CONTROL OF THE U.S. PUBLIC HEALTH DEPARTMENT.

Dirk Verhoeff, M.D., Chairman

COMMITTEE ON COMMUNITY MEDICAL CARE

The committee at its annual meeting and in subsequent subcommittee sessions worked out a final INSTITUTIONAL CLERKSHIP PROPOSAL to be presented to the legislature for funding. Each medical school in the state has been offered an opportunity to participate. A continuing dialogue with Mr. Jim Bernstein about the governor's rural health program has been continued.

J. Kempton Jones, M.D., Chairman

COMMITTEE ON COMPREHENSIVE HEALTH SERVICE PLANNING

The Committee on Comprehensive Health Service Planning has been active in the past year with the change in the Federal law on Comprehensive Health Planning. A report at our committee meeting in Southern Pines on September 26, 1974, concerned changes in this law. Mr. Larry Burwell, Chief of Comprehensive Health Planning for the State of North Carolina, was heard. Since that time, Federal Legislation has changed the Comprehensive Health Planning aspect and the Health Service Agency has been instituted and will become effective January 1, 1975.

The committee along with the Executive Council has been active regarding the effect on the State of North Carolina and continues to work with the Advisory Councils on Comprehensive Health Services planning in formation of the areas to be designated. At the present time, these areas have not been designated. It would appear that the present aim is to reach some modification of the present areas now designated and to try, in some way, to simulate the PSRO Boundaries. Continued input from the Executive Council of the North Carolina State Medical Society is anticipated.

The committee continues to encourage practicing physicians to acquaint themselves with the Comprehensive Health Planning Councils and to serve them in whatever way may be beneficial to both the council and to the individual physician.

Robert C. Moffatt, M. D., Chairman

COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee has completed a working copy for revision of the Constitution and is working on revision of the Bylaws.

In its report to the House of Delegates, the Committee will submit for final action several proposed changes in the Bylaws:

1. Intern-Resident members to have some privileges as active members,
2. Blue Shield Committee members to be appointed rather than elected,

3. Medical Education Committee to be assigned to and made part of an Annual Convention and Education Commission, and
4. Jones County be hyphenated with Craven-Pamlico Medical Society.

Louis Shaffner, M.D., Chairman

COMMITTEE ON CREDENTIALS

The Committee on Credentials held one meeting on September 26, 1974 at Mid Pines Club.

The committee discussed the continual bottleneck experienced by the Committee on Credentials just prior to the opening session of the House of Delegates when they certify delegates to be seated in the House.

The following procedure was agreed upon and will be followed at the 1975 Annual Meeting in certifying delegates.

Each delegate will present his credentials card at the time of registration at the regular registration desk, and after being checked off against a prepared list of elected delegates (certified by the county medical societies, specialty sections and student societies) will be issued a Delegates' Badge — (red ribbon with the word "Delegate" imprinted attached). When the House of Delegates is convened and the Speaker calls for a delegate count, the Credentials Committee will merely make an announcement as to the number of registered delegates and the number of delegates seated in the House can be counted by a visual check to ascertain that a quorum is present. A further visual check can be made to make sure that all persons seated in the House are wearing either a delegate or an alternate delegate ribbon in order to qualify for voting.

A member of the Credentials Committee will be present at the Desk in the Registration Office on Thursday morning, May 1, from 8:30 a.m. to 12:30 p.m. to handle any problems that might arise regarding any questionable case, such as a person not having a duly signed credentials card.

The question was raised as the need for tables to be marked by counties with the appropriate number of seats for each county. It was felt that this was not necessary at this time.

It was recommended that a letter from the Headquarters Office be sent to the Delegates and delegates-at-large advising of the change in the procedure for certifying delegates at the meeting of the House of Delegates, also, emphasizing that badges must be worn to be seated in the House of Delegates.

John A. Payne, III, M.D., Chairman

ADVISORY COMMITTEE TO CRIPPLED CHILDREN'S PROGRAM

The Advisory Committee to the Crippled Children's Program of the North Carolina Medical Society had no business to come before it except for the annual meeting we had September 25, 1974.

Considerable discussion was held concerning the attendance at the Crippled Children's Clinics of Orthotists and Prosthetists. It was the committee's recommendation that:

1. CERTIFIED PROSTHETISTS/ORTHOTISTS WOULD NOT BE REQUIRED TO ATTEND THE ORTHOPAEDIC CLINIC;
2. IT IS TO BE ENCOURAGED THAT THE ORTHOPAEDIC CLINIC BE ATTENDED BY PERSONNEL OF A CERTIFIED PROSTHETIST'S SHOP, and

3. TO THIS END WE WOULD RECOMMEND TRAINING IN THE PROSTHETIC/ORTHOTIC FIELD BE MADE AVAILABLE IN EXISTING TECHNICAL SCHOOLS, COMMUNITY COLLEGES, AND STATE UNIVERSITY SYSTEMS. THESE RECOMMENDATIONS ARE MADE IN VIEW OF INCREASING ACADEMIC REQUIREMENTS BY THE ORTHOTIC/PROSTHETIC BOARD.

The other matter that was discussed at length was the overall problem of care of the cleft palate/cleft lip child. The following recommendations were made:

1. THE TEAM APPROACH TO THIS PROBLEM IS DESIRABLE AND THAT THE MOST LOGICAL DISCIPLINE TO HEAD THIS TEAM WOULD BE A PEDIATRICIAN. IT WOULD BE RECOMMENDED THAT HE BE COMPENSATED FOR HIS SERVICES RENDERED.
2. UNDER THE DISCRETION OF THE TEAM LEADER (THE PEDIATRICIAN) THE CHILD COULD THEN BE REFERRED TO THE APPROPRIATE DISCIPLINES FOR EVALUATION AND CORRECTION OF THIS PROBLEM; WE RECOMMEND THAT A COMPLETE TEAM APPROACH CONSIST OF THE FOLLOWING: A CONGENITAL CLEFT SURGICAL EVALUATION; AND AUDIOLOGIC EVALUATION AND SPEECH EVALUATION.
3. IF THE TEAM LEADER CAN ARRANGE THESE EVALUATIONS TO BE CARRIED OUT LOCALLY, THERE WOULD BE NO NEED FOR REFERRAL TO ONE OF THE THREE MEDICAL SCHOOLS.

It is the request of the membership of the committee that problem's concerning the Crippled Children's Program, from the membership at large, be voiced to the committee so that such problem areas can be easily identified and hopefully solved.

Robert G. Underdal, M.D., Chairman

COUNCIL ON REVIEW AND DEVELOPMENT

The Council on Review and Development met February 1, 1974 and again on September 28, 1974. Among the items considered were the handbook on committee guidelines with particular reference as to is distribution following the original publication of the handbook. The committee advised that a master looseleaf copy should be kept updated at the committee headquarters and that appropriate sections of the handbook should be provided for committee chairmen and members as necessary for continuity provision and for definition of the function of the various committees of the Medical Society.

The Council also discussed the possibility of establishing a History Room or other facility for preservation and/or display of historical records of the Medical Society to be kept at the Headquarters. It was agreed that the consultation of Mrs. Eunice Drum of the North Carolina State Library and Archives be sought in developing a format for this activity.

The committee recommended disbanding of the North Carolina Medical Society Committee on Archives and History and also recommended to the Executive Council that the Medicare Committee be dropped and that its functions be added to the Insurance Industry Committee. The Committee Liaison to the Woman's Auxiliary was retained.

The Council on Review and Development at the September 1974 meeting recommended to the Executive Council that the Committee on Medical Education be assigned to the Annual Convention Commission and that the name of the Commission be changed to the Annual Convention and Education Commission.

The Council also recommended that the Committee on Arrangements and the Committee on General Sessions Program be combined and that the other four committees of the Annual Convention Commission remain as separate committees.

The Council also discussed the possible merits of the establishment of a grant or loan fund for disabled members of the North Carolina Medical Society or their families. No definite action on this was taken. The proposal is to be further discussed at future meetings.

John Glasson, M.D., Chairman

COMMITTEE ON DISASTER AND EMERGENCY MEDICAL CARE

This past year saw the establishment under the Department of Human Resources the "Office of Emergency Medical Services." Mr. James O. Page assumed the directorship of this organization and assembled staff to implement directories of legislative mandate. This office functioned under the surveillance of a state Emergency Medical Service Advisory Council. Former State Senator O'Neill Jones headed the Council which included physician members.

At the fall Committee Conclave Mr. Page reported to the members of the Committee on Disaster and Emergency Medical Care on the progress of his office and the overall Emergency Medical Program in the State. The training of ambulance attendants was discussed and the need for further training of this group explained. Mr. Page asked for and received support of his position by the Society.

Mr. William Henderson spoke briefly of his plans for attracting full time emergency room physicians to smaller hospitals. Representing three North Carolina foundations he told of his plans of offering twenty thousand dollars per year, of foundation funds to finance this project. The Committee approved of his plans, thanked Mr. Henderson and promised their support.

In January, Mr. Page was removed as director of the Office of Emergency Medical Services by administrative action. Col. Charles A. Speed has been appointed to fill this position. Col. Speed, in previous positions, has been Commander of the Highway Patrol and Coordinator of the Governor's Highway Safety Program. Members of the committee have previously worked with Col. Speed in past years.

George A. Watson, M.D., Chairman

COMMITTEE ON DRUG ABUSE

The Committee on Drug Abuse was involved throughout the year in a number of issues and activities through its individual members and as a committee.

Individual members had direct input into drug abuse treatment and education programs in their own localities, but were also consulted by drug abuse programs and interested parties in other areas of the state.

The Committee, through its Chairman, had input into the subject of the use of triplicate prescription blanks as a means of providing checks on one possible avenue of drug diversion. This device was presented to the North Carolina

Drug Authority as a matter for possible legislative action.

The Committee also had input in the matter of proposed federal legislation dealing with the confidentiality of alcohol and drug abuse patient records. (A hearing was held in Raleigh on October 7, 1974 at which all agencies concerned with confidentiality of client records were invited to testify.)

The Committee as a whole met at Southern Pines on September 27, 1974. A copy of the minutes of that meeting is on file at the Headquarters Office. In addition to the review by Mr. Epps of the North Carolina Drug Authority of its activities for the year to date and the activities of drug abuse programs around the state, there was considerable discussion of the matter of how to handle the physician who personally abuses drugs and also of the matter of laws dealing with prescribing practices by physicians. The Committee recommended that the Medical Society, through its news media, review for its membership the laws regarding prescribing practices.

William J. K. Rockwell, M.D., Chairman

COMMITTEE ON EYE CARE AND EYE BANK

Following is a synopsis of the report of the committee on Eye Care and Eye Bank.

This committee met in September at the annual committee conclave and the many items on the agenda were taken up. A committee was appointed to study and prepare recommendations in an attempt to correct the fee disparities on the Medicaid schedule between the ophthalmologists and the optometrists.

Dr. Wayne Woodard was commended and reappointed to his position as chairman of the Professional Advisory Committee to the North Carolina State Commission for the Blind. The committee also went on record as being opposed to dual staffing of clinics sponsored by the Blind Commission and gave their approval to the use of properly trained registered nurses, LPN's and registered physicians assistants in enucleation of eyes donated to the Eye Bank.

The committee has also been asked to assist the Physical Fitness Board in making recommendations for visual standards for drivers in North Carolina. This project is currently being activated.

E. W. Larkin, Jr., M.D., Chairman

COMMITTEE ON EXHIBITS

At the May, 1974 session of the Executive Council of the North Carolina Medical Society, the name of this committee was changed to the Committee on Exhibits signifying the functions that fall to its charge. These functions are, of course, the supervision of both scientific exhibits and technical exhibits as well as the solicitation of scientific exhibits for the Annual Session.

At the 120th Annual Session of the North Carolina Medical Society awards for excellence were presented to John L. Sawyer, M.D. for his exhibit, REMEDIAL OPERATIONS FOR POSTGASTRECTOMY SYNDROMES and to Kenneth B. Lewis, M.D. for his exhibit, RECHARGEABLE CARDIAC PACEMAKER. Due to the excellent quality of all of the scientific exhibits, the judges found themselves in the unhappy position of having to make a choice.

Solicitations of exhibits for the 1975 Session have been made and responses thus far have been excellent.

Josephine E. Newell, M.D., Chairman

COMMITTEE ON FINANCE

The Finance Committee met in early September, 1974, and compiled a proposed budget for the year 1975. The format of the budget was changed a little so that it would include all of the income and all of the expenditures of the North Carolina Medical Society including return on investments and sums of money to be added to the Society's reserves. The proposed budget was accepted and approved by the Council as reported to them at their meetings in September and again in January.

The Society's operating budget for 1974 when audited was found to be approximately \$6000.00 in the red. Since the operations in 1973 had wound up with an operating surplus of approximately \$60,000.00, the deficit in 1974 caused no difficulty. It is to be noted that the deficit was \$6000.00 after allocations of all monies to the Reserve Fund and after purchase from the operating budget of two houses and lots in back of the Medical Society Headquarters building. These two houses came on the market at what was felt to be a reasonable price and were purchased by the Medical Society with the intent of continuing to rent them for the present and to use the ground when it becomes desirable as additional parking area for the Headquarters building. The price of the two 50 foot lots was approximately \$35,000.00.

One dark spot in the financial picture is the fact that International Developers, Inc., a Gastonia based corporation which had purchased the highway 70 property belonging to the Medical Society was unable to meet the payment on the mortgage in December, 1974. On the advice of our counsel, no action has been taken on this. The Medical Society's lien on the property is such that it can be repossessed at any time, and since the mortgage calls for payment of interest on all overdue payments, the Finance Committee saw no advantage to the Society to repossess the property unless we had another sale for it. So far as is known, the International Developers, Inc. has no business other than development of this piece of property.

T. Tilghman Herring, M.D., Chairman

GOVERNOR'S COORDINATING COUNCIL ON AGING

This committee of 21 members, 20 of whom are appointed by the Governor of North Carolina upon a strict federal formula and one appointed by the State Medical Society, has met, quarterly, on February 7th, 9 May, 8 August, 1974 and 6 February 1975.

This committee remains in limbo. It has been relegated in the state reorganization plan to "advisory" capacity and without any mechanism for input into any of the programs or disbursement of funds. The work of the committee is carried out primarily by an executive director who, in turn, is responsible to the Department of Human Resources of the State of North Carolina and to the federal representatives assigned to North Carolina who are said to supervise the total distribution of all federal funds released in North Carolina.

The total budget for this committee in the fiscal year 1973 was about \$500,000.00. Our total budget for this current fiscal year 1974, for the Council and all projects including non-federal funds, amounts to approximately \$5,300,000.00. This means that the total budget for Older Americans Act Programs in North Carolina has increased nearly 10 times in 12 months. To handle this fantastic increase in funds, the office has expanded from six to 23 employees. The rather complicated breakdown in this budget for fiscal year 1974 is on file at the Raleigh offices of the North Carolina State Medical Society.

In general discussion, it is the sense of this committee that this office is limited to carrying out the distribution of combined monies (mainly federal and state tax funds) to politically oriented minorities, totally subject to federal monitoring and regulation. This appears to be without regard as to the actual needs, person participation, unit costs, plans for continuation or ultimate evaluation.

Actually, it is one part of an increasing federal transfer of funds, collected from the taxpayer, to minority, non-productive groups.

The above sentiment was expressed at the last meeting of 6 February 1975 and a resolution was passed by unanimous vote denying committee responsibility for the handling of any of the above funds.

It is possible that the present distressing economic situation may influence the subsequent course in redistribution.

Thomas R. Nichols, M.D., Representative

COMMITTEE ON HOSPITAL & PROFESSIONAL RELATIONS & LIAISON TO NORTH CAROLINA HOSPITAL ASSOCIATION

The Committee held its annual meeting at the State Society's "Committee Round-Up" at Southern Pines in September 1974 and its recommendations are filed in the Minutes of that meeting. No specific resolutions were made at that time.

Since its appointment, this Committee has had only one request from a physician regarding his conflict with the administrators and staff of the hospital regarding their Emergency Room roster. This was investigated and I hope resolved by several telephone calls to the physician involved and the administrator of the hospital involved, made by the Chairman. No formal hearing was held, and no written minutes made. This is the only request for a mediation we have had to date.

J. M. Van Hoy, M. D., Chairman

INSURANCE INDUSTRY COMMITTEE

The Insurance Industry Committee of the North Carolina Medical Society had regular meetings on July 17, 1974, September 25, 1974, and on January 15, 1975. Approximately 100 individual claim disputes were arbitrated with subsequent settlement. Excellent physician-member attendance has been notable.

Since September, 1974, insurance carriers have been paying \$25.00 per case submitted to cover Medical Society costs of handling the claims; this has enabled the committee to reduce the actual budget cost to the Medical Society.

Numerous other problems have been handled by the committee including insurance company contractual language with Celenese Corporation in the Charlotte area. A dispute between Prudential Medicare and anesthesiologists who hire nurse anesthetists is now being handled through this committee.

Generally, the efficiency of the committee's work excels through the cooperation of the private insurance carriers and the committee members.

Charles H. Duckett, M.D., Chairman

COMMITTEE ON LEGISLATION

The work of your legislative committee continues to be interesting and demanding. Improvements in the number of physicians involved in political activity is encouraging. Largely because of the effective work of Steve Morrisette

and John Anderson our list of county legislative chairmen and key contact physicians continues to expand. Each new legislator requires us to find new key contact physicians. We need your help in this effort. If you are medicine's best contact for a particular legislator, let us know.

A major project of the committee — a practical politics seminar — is taking shape. This project will involve about 100 doctors and 25 legislators and administrators in a political education seminar in Boone in September. The legislators will act as teachers and the doctors as students. The seminar is part of the committee's ongoing effort to create a larger group of politically informed and effective physicians who will help us to bring better medical care to North Carolina by helping to guide the legislative process in health matters.

As this report is being prepared the 1975 session of The General Assembly is just getting underway. Again about 10% of the legislation presented will relate to the practice of medicine (about 400 to 450 bills).

The committee monitors this legislation and provides medicine's position on the various issues. To aid in this effort this year the committee prepared a pamphlet for the legislators outlining our view of several current issues.

No effort will be devoted in this annual report to discussion of specific issues. This is better handled by our ongoing publication — the Legislative News.

H. David Bruton, M.D., Chairman

COMMITTEE ON MARRIAGE COUNSELING AND FAMILY LIFE EDUCATION

The committee has had one meeting. At that meeting, a copy of a bill to certify marriage counselors in the state of North Carolina was considered. This bill had been forwarded by the local branch of the American Association of Family and Marital Counselors. It was a consensus of the negatives with regard to this bill that it was too restrictive and would exclude physicians who had been practicing various forms of marital counseling in association with the practice of medicine and, as such, was not acceptable in its present form. This was similar to the opinion of the Legislative Committee of the N.C. Medical Society who had independently considered this bill. The letter was sent by me to the Chairman of the Legislative Committee identifying that I also concurred with the non-approval of the bill in its present form.

A look was made at the possibility of having a one-day workshop on sexual counseling as an aid to members of the state society but the logistics of putting on the course was such that, in my opinion, either the fee would be too high to support the program — or if a lower fee were charged, then the caliber of the instructors would be less. It was intended to bring in outside speakers of some repute but this would be too expensive. Additionally, no less than five courses on marital and sexual counseling were identified as being available to members of the state society in the southeastern region so it was felt that replication under the circumstances originally thought through by myself would be an unnecessary replication. This matter will be considered at the next full meeting of the committee in September of 1975.

John Reckless, M.D., F.A.C.P., Chairman

COMMITTEE ON MATERNAL HEALTH

The Committee on Maternal Health continues to function in the capacity of answering all queries to the State

Medical Society concerning maternal health and in formulating relevant opinions and recommendations for consideration on behalf of the Medical Society. The Committee also continues to actively investigate and analyze the maternal deaths which occur in North Carolina each year.

The maternal deaths surveyed during the year 1974 included a total of 21 maternal deaths. There were nineteen counties reporting and Burke and Robeson Counties had two each. The remaining seventeen counties reported only one each.

There were eleven maternal deaths in white women, nine in Negro, and one was an Indian woman. Seventeen of these maternal deaths were due to direct obstetric causes consisting of one from anesthesia, four due to toxemia, seven due to hemorrhage, four due to embolism, and one due to cardiac disease. There was one other obstetrical and three non-obstetrical deaths. The four toxemia deaths represent the same number which occurred in 1973. However, the seven hemorrhage deaths are more than double the three which occurred in 1973.

The Chairman wishes to express appreciation to the Executive Council and Staff of the State Medical Society for their continued support and cooperation in the activity of the Committee on Maternal Health. A request has been submitted for reimbursement of three hundred dollars to cover expenditures for secretarial help, mailing, supplies, and telephone expenses incurred in the course of conducting the work of the Committee for the year.

W. Joseph May, M.D., Chairman

COMMITTEE ON MEDICAL ASPECTS OF SPORTS

During 1974 the Committee on the Medical Aspects of Sports was composed of Frank C. Wilson, M.D., Chairman; Frank H. Bassett, III, M.D.; James F. Bowman, M.D.; Basil M. Boyd, M.D.; Frank W. Clippinger, Jr., M.D.; James R. Dineen, M.D.; William A. Herring, M.D.; Carl J. Hiller, M.D.; A. Tyson Jennette, M.D.; Donald B. Reibel, M.D.; Timothy N. Taft, M.D.; Richard N. Wrenn, M.D.; George D. Rovere, M.D.; Joseph L. DeWalt, M.D.; Roger A. James, M.D.; and Wayne F. Montgomery, M.D. with David A. Harris, Jr., Al Proctor, Raymond K. Rhodes.

There were two meetings of the committee during 1974. One was held at the Blockade Runner Motor Hotel at Wrightsville Beach on July 4 and the other at the Pinehurst Hotel on October 24.

The major activity of the Committee during 1974 was the sponsorship of the Fourth Annual Sports Medicine Symposium held over the 4th of July weekend at Wrightsville Beach. The attendance for this symposium exceeded any previous symposium, and it is planned to continue these meetings as an annual function of the committee. The 1975 symposium will be held next July in Boone to accommodate the physicians in the western part of the state. Course evaluations submitted by those who attended the 1974 symposium indicated that the meetings are serving an increasingly valuable and important educational function.

The Committee also continued its efforts to secure utilization of the recommended athletic participation form by all junior high and high schools in the state. Because of the relative complexity of the form, the State Board of Education has been somewhat reluctant to make it mandatory, however.

Efforts are being continued to obtain the appointment of representatives from each county medical society who are willing to undertake the responsibility for sports medicine

in their respective counties. So far, approximately one-third of the county medical societies have responded by appointing such an individual or individuals.

In accordance with its primary responsibility of education, the committee also volunteered to provide to the State Board of Education medical position papers on some of the issues facing interscholastic athletics in the state; for example, the role of the team physician in the prevention and treatment of athletic injuries. These issues will be further defined by the State Department of Public Instruction Division of Sports Medicine and medical input sought from the committee.

Frank C. Wilson, M.D., Chairman

COMMITTEE ON MEDICAL EDUCATION

The Committee met twice during the year. Dr. Christopher Fordham and his associates presented a review of the AHEC Program on February 21. The committee resolved at the conclusion of the presentation that it should re-affirm its support of the AHEC Centers throughout the state of North Carolina.

A second meeting on September 26, 1974, encompassed the initial discussions of a reporting system for compulsory continuing medical education as required under the amended bylaws of the North Carolina Medical Society. The final proposal passed by the committee was that the AMA's Physician Recognition Award or membership in the Academy of Family Physicians would automatically fulfill the requirements of the compulsory continuing education. In lieu of satisfactory compliance with those criteria, 150 hours of education activities including courses or activities sponsored or approved by medical educational centers and agencies, medical societies, medical specialties or scientific societies be accepted without limits. Self instruction up to a maximum of 75 hours would also be accepted.

It was also decided that a pocket size reporting form be used and the final development of the form is being completed.

A significant portion of this meeting was related to the discussion of goals of continuing education and the function of this committee in achieving these goals.

Consideration of the role of the North Carolina Medical Society as an accrediting agency approved by the AMA to accredit programs in continuing education was discussed and further consideration of this function will be made at meetings in 1975.

Albert L. Chasson, M.D., Chairman

MEDICAL-LEGAL COMMITTEE

A meeting of the Medico-Legal Committee was held on September 25, 1974 and a joint meeting of the Medico-Legal Committees of the Medical Society, and North Carolina Bar Association was held on November 24, 1974. Ways and means to improve the medico-legal relationship and to educate members in this regard were discussed at these meetings. The following suggestions were made: 1. The increased use of the Interprofessional Code. 2. The use of bulletins published by the Bar Association and the Medical Society to inform the membership of medico-legal matters. 3. A recommendation to the law schools and medical schools of North Carolina that medico-legal subjects be included in the curriculum. 4. That each county bar association and county medical society have at least one medico-legal program per year.

Screening panels were discussed and the committees position of opposition to a panel screening plan was reaffirmed.

The matter of request by attorneys for medical review of malpractice cases was discussed and the committee reiterated its policy of not undertaking such a review with the suggestion that the attorneys themselves arrange for medical review.

A report on the survey of penal institutions in North Carolina was made. 38.5% offered first aid only and 12.8% had no medical facilities. It was recommended that some type of certification of medical facilities be considered. The results of this survey were sent to the North Carolina Bar Association.

Joint meetings were held in approximately 45 counties. No instance of alleged unethical action on the part of the physician has been reported to the committee.

Julius A. Howell, M.D., Chairman

COMMITTEE ON MEDICARE

(Report not received March 20, 1975)

COMMITTEE ON MEDICINE (RELIGION)

The Committee on Medicine and Religion met during the Annual Committee Conclave in September 1974, at Mid Pines Club in Southern Pines and again on January 31, 1975 at the Headquarters Office.

The Committee has the responsibility for planning the Medicine and Religion Breakfast held during the Annual Sessions of the Medical Society in remembrance of deceased physicians and Auxiliary members. Final plans for this Breakfast was set up at the January meeting. The Breakfast is scheduled for Friday, May 2, 1975, at 7:30 a.m. in the Crystal Room, Pinehurst Hotel. Dr. Bruce Blackmon, a member of the Committee has arranged for a Soloist from Campbell College to sing at the Breakfast.

Jack W. Wilkerson, M.D., Chairman

COMMITTEE ON MENTAL HEALTH

The year 1974 was another very active one for the Mental Health Committee. As in 1973, the statutes concerning voluntary commitment presented problems. The Committee was concerned that the current law urges that the patient being considered for commitment should be taken to the community mental health center and that there was no mention in the law of private psychiatry. The Committee therefore recommended to the Medical Society that it take notice of what it regarded as one of the many unconstitutional points in the commitment law, and that this be changed.

The Committee was also very active in the field of alcoholism. The Committee recommended that the Medical Society encourage the governor to proclaim an Alcoholism Awareness Week in North Carolina. Such an Alcoholism Awareness Week was proclaimed and the North Carolina Alcoholism Research Authority, of which one of our members is Executive Director and another is Vice Chairman, was very active in this effort. The program was earnestly supported by the North Carolina Medical Society which had as its guests over eighty legislators at the dinner celebrating the event in Raleigh.

Two of the Committee members had been quite active on

the Nurse Psychiatric Task Force and it is hoped that this report will shortly be completed.

Under the leadership of Dr. Blackley, representing the Division of Mental Health Services there has been an increasing degree of cooperation and communication between the Medical Society and the Division of Mental Health Services. Dr. Noel Lazade from the Division of Mental Services spoke to our Committee in September about the Legislative Study Commission and, the Model Area Program which he said would have three basic goals:

1. To look into the long range financing of the State system as a whole and the organization of the State system.
2. To draw up a set of recommendations which has to do with specific services of mental health services.
3. To draw up a set of activities which will revolve around designing and implementing an information system to give information to local providers, area directors, regional offices, state offices and to the Department of Human Resources.

The Committee has also been very active in the formation of a Utilization Review Procedures Committee for Community Model Mental Health Centers. Dr. Osberg presented to the Committee in September the basic ideas behind the proposal for which funds are being sought from the National Institute of Mental Health. One purpose is to find additional sources for funding, for continuing education and training and another is to find a better way of collecting data to see what might be happening in the entire mental health field. It is our expectation that a manual of the Utilization Review Procedures will be developed as the four model mental health centers are studied. Drs. Harper and Nelson were appointed by the President of the Society to work with those seeking to make a grant application entitled "PSRO Model — Utilization Review Procedures For Community Mental Health Centers." The Committee felt strongly that these representatives should strive for the maintenance of high quality of care which we feel should be applicable to both public and private psychiatry.

Last, but far from least, the Committee was very active in the American Medical Association's Southeastern Regional Conference of Mental Health Representatives which was held in the spring in Atlanta. The Committee chairman was coordinator of this conference which was attended by almost forty North Carolinians.

Philip G. Nelson, M.D., Chairman

ADVISOR TO AAMA-NORTH CAROLINA STATE SOCIETY

(Medical Assistants)

Organized with three chapters April 1963

Total membership at present (2/1/75): 444

Total number of local chapters: 22

Chapters in process of organization: 3

Counties now represented: Buncombe, Burke, Cabarrus, Carteret, Catawba, Charlotte — (Mecklenburg), Coastal — (Jones), Cumberland, Harnett, Durham, Orange, Forsyth, Guilford, Haywood, High Point, Lenoir-Green-Jones, Moore, Onslow, Pitt, Rowan-Davie, Stanly, Union, Wake, Wilmington — (New Hanover).

Counties now in process or organizing: Robeson, Wayne, and Avery-Watauga.

State-wide Educational Seminars this past year: August — Leadership Institute, November — Medical Assistants' Role, February — Tour of Medicare Facility-Prudential, and Geigy Medical-Legal film

PRESIDENT'S NEWSLETTER: a monthly report to the local chapters by the State President was started this past year and has been well received by the membership.

TEMPO — the quarterly publication of the NCSS for its membership was entered in the national contest for state publications and received second place.

Miss Joan Michaels, AAMA-NCSS past president was elected AAMA Vice-President at the annual meeting of the American Association of Medical Assistants in Denver, Colorado. Thirteen North Carolina members attended the meeting.

The **TENTH ANNUAL MEETING** of the AAMA-North Carolina State Society will be held MAY 16-18, 1975, at the **BLOCKADE RUNNER MOTEL**, Wrightsville Beach. James E. Davis, M.D., President of the North Carolina Medical Society, will be guest speaker, as well as Michael Silver of Medical Management Consultants and Donald Kai Wallace, M.D. and George Rountree, Attorney.

The NCSS medical assistants will be hosting the Coffee Bar for the North Carolina Medical Society during their Annual Meeting at the Pinehurst Hotel, Pinehurst, May 1-4, 1975.

CERTIFICATION of all the North Carolina members is the goal for the coming year NCSS. Realizing the importance of educated personnel in the offices of the physician of our state, the education and certification committee is working with each chapter in realizing the most benefit available for the working medical assistant.

The current NCSS President is Mrs. Ruth M. Patterson, CMA-A. Ruth works for Fred Craven, M.D., Concord.

Emmett S. Lupton, M.D., Advisor

COMMITTEE TO WORK WITH NORTH CAROLINA INDUSTRIAL COMMISSION

The Committee reports another busy year which was made more bearable by the splendid cooperation of Dr. John Morris and the Commissioners and workers at the Industrial Commission in Raleigh. All the members of the committee as well as other consultants throughout the state went about the work of the committee in a diligent and forthright manner and their reports were punctual and informative. The attendance at the annual fall Committee Meeting was excellent and, at that time, it was decided to bring out a supplementary fee schedule for some procedures that are now not listed in the present fee schedule. It is planned also to revise upward some of the fees that are distinctly out of line in light of the present situation. The committee would solicit any complaints or comments that you might have in regards to the work of the committee.

Ernest B. Spangler, M.D., Chairman

COMMITTEE LIAISON TO NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

There was only one meeting held by the full committee, which was on September 26, 1974 at the Annual Conclave Meeting in Southern Pines. As chairman, I have received much correspondence as information for this committee. At our meeting on September 26, 1974 the following actions were taken:

- I. Mr. Benny Ridout of the North Carolina Department of Social Services reviewed all the physicians dispensing under Medicaid. The following six physicians were approved for dispensing of drugs under Medicaid: Moyock, Hatteras, Gatesville, Engelhard, Jackson and Richlands.

- II. Dr. McCain requested that Mr. Ridout give the committee a progress report or analysis of the Peer Review of Drug Utilization at its next meeting for information.

Mr. Ridout advised the committee that a documentary film had been prepared showing some peer review committee at work and that this was available to medical societies and other groups who wished to use it. It was suggested that this information be printed in the Public Relations Bulletin.

- III. Mr. Smith reviewed the survey sent out on authorizing refills by physicians. He reported he received a 70% return and reported the trend of physicians charging \$2 to \$3 fee for telephone refills on prescriptions because of the work involved in pulling charts, etc. He suggested that guidelines might be considered as the trend increases.

- IV. Mr. Smith then submitted a suggested schedule #2 drugs in Emergency Drug Kits in Nursing Homes as proposed by Mr. Seth Miller of Lexington, a pharmacist.

Considerable discussion followed on this subject and the committee finally passed the following motion: **THE COMMITTEE SET UP AN AD HOC LIAISON COMMITTEE TO STUDY MEDICATIONS IN EMERGENCY MEDICAL KITS IN INSTITUTIONS OF LONG TERM CARE, CONSISTING OF THREE REPRESENTATIVES FROM THE MEDICAL SOCIETY, PHARMACEUTICAL ASSOCIATION AND NURSING ASSOCIATION, WITH CONSULTANTS TO BE CALLED IN WHEN NEEDED (TOTAL OF NINE MEMBERS).**

The Committee members are: Charles W. Byrd, M.D.; John L. McCain, M.D.; and John A. Payne, III, M.D.

- V. Item of information for publication in the Public Relations Bulletin:

"That either the signature of the physician or patient is permissible and acceptable for the pharmacist to supply certain patients with regular closure prescription containers."

- VI. Mr. Morrisette informed the committee that on the problem of LPN and nurses aides dispensing drugs in intermediate care facilities, this was being pursued by a sub-committee of the nursing association and he would report back.

- VII. Mr. Morrisette outlined the need for a policy statement from the North Carolina Medical Society on Drug Substitution laws in the event of legislation and the committee passed the following motion: **THE COMMITTEE RECOMMENDED THAT A SPECIAL STUDY COMMITTEE BE APPOINTED BY THE CHAIRMAN.**

The committee members are as follows: T. Reginald Harris, M.D.; Edgar T. Beddingfield, M.D.; and Richard A. Fewell, M.D.

Charles W. Byrd, M.D., Chairman

COMMITTEE ON OCCUPATIONAL AND ENVIRONMENTAL HEALTH

The Committee met on Friday, September 27, 1974 during the Committee Conclave at Southern Pines, North Carolina. Chairman, Dr. Harold Imbus recognized John Lumsden who reported on the progress of State Oc-

cupational and Environmental Health activities. Mr. Lumsden said there was increasing public awareness in the field of occupational health and safety matters and that this awareness was causing stepped-up federal pressure to increase the activities not only in North Carolina but across the country. He also said that OSHA programs were being implemented in a very hurried fashion and in many instances, technology associated with the OSHA program had not caught up.

Mr. Lumsden said that until this time inspections had mainly been confined to a referral system of problems. Mr. Lumsden concluded his report by discussing the Division of Health Services which now has a staff of about 30 people. He said that he hopes soon to have health and field work generated by the degree of severity of the health problems rather than the safety factor.

Following Mr. Lumsden's report, Dr. Imbus recognized Dr. David Fraser who reported on the Occupational Health activities in the post-graduate program at the University of North Carolina at Chapel Hill. Dr. Fraser discussed the study agreement entered into by the University of North Carolina with four of the nation's leading rubber producers. Under this agreement, the schools in cooperation with the union would study approximately 70,000 workers in 75 plants across the country.

The Committee then discussed its functions and programs for 1974-1975 and recommended several things to the Executive Council through motions. Included in the recommendations was: a request that the Medical Society provide the widest possible dissemination of information on occupational health and safety items through publications to its membership; that the information be disseminated through the *North Carolina Medical Journal*, *Public Relations Bulletin*, the President's Newsletter, special flyers and also the redistribution of the Policy Statement of the North Carolina Medical Society's Committee on Occupational Health; that a program be presented in 1976 at the Annual Meeting on Occupational and Environmental Health and finally the State Medical Society sponsor a group of resource physicians to be available to interested groups as speakers and/or for the program on Occupational Medicine at Duke University on February 7-8, 1975. The Medical Society co-sponsored and staffed that program.

COMMITTEE ON PEER REVIEW

The Committee on Peer Review met in September and recommended to the Executive Council that a more active committee be developed with funding to help implement the problem of peer review to function in a similar fashion to the Blue Shield Committee and the like.

The Executive Council did not feel that this was the proper approach at this time.

There have been no further activities.

M. Frank Sohmer, Jr., M.D., Chairman

COMMITTEE ON PERSONNEL AND HEADQUARTERS OPERATION

The Committee met prior to the meeting of the Finance Committee. A salary increase from 10% to 17% for employees of the Medical Society was recommended and was adopted later by the Finance Committee.

The Committee recommended that no major improvements be made to the newly acquired house and lot on Bloodworth Street.

New Field Representatives have been employed by the

Society. Mr. Michael Cates began work in July, 1974. Mr. John Evenson began work in August, 1974.

A. Hewitt Rose, M.D., Chairman

COMMITTEE ON PHYSICAL AND VOCATIONAL REHABILITATION

This committee met at the annual committee conclave and discussion was held regarding the developing rehabilitation program in the state. There were no fee problems. This was a change from previous years in which there have always been some fee problems presented by members of the Medical Society to the state Vocational Rehabilitation Agency. It would seem that this problem is evidently under better control. Recommendations were made regarding the possible sponsorship of the state Medical Society of meeting representatives from the medical schools in the state with members of the committee to discuss problems of teaching of rehabilitation in the medical schools. No definite action was taken on this in the executive committee, but it is hoped by this committee that such a meeting can be arranged in the future.

E. H. Martinat, M.D., Chairman

CONSULTANT ON PODIATRY

In 1974, there have been no new matters pertaining to Podiatry brought to my attention; therefore, I have nothing new to report in this regard.

Donald B. Reibel, M.D., Consultant

COMMITTEE ON PROGRAMS FOR GENERAL SESSIONS

The Committee on Programs for General Sessions met during the Committee Conclave in September and followed the procedure and format as set up the previous year in planning the programs for the First, Second and Third General Sessions. The medical schools preparing and presenting the programs this year are: University of North Carolina — Medical Session; and Duke University Medical Center — Surgical Session. The Third General Session is planned as a Socio-Economic Session. These Sessions are scheduled for Friday, May 2; Saturday, May 3, and Sunday, May 4 from 9:00 a.m. to 12:30 p.m. each day.

The General Sessions program has been accredited for six hours (6) by the AAFP.

T. Reginald Harris, M.D., Chairman

COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations met at the Mid Pines Club in Southern Pines on September 26, 1974, and planned the year's activities as listed below

1. Continue the PUBLIC RELATIONS BULLETIN with periodic review of its format content and presentation to maintain relevance and readability.
2. Continue the North Carolina Academy of Science award at \$50.
3. Revise the INFORMATION PACKET FOR PHYSICIANS for distribution to new members with the help of the Headquarters staff.
4. Continue the project to give an award to the winner of the North Carolina Rescue Squad First Aid competition presented by a member of the Committee.
5. Conduct a Conference for Medical Leadership on January 31 and February 1 on the theme topic

"Problem Oriented Record". New invitees this year also included presidents of medical specialty organizations. The Conference was attended by 254. The Conference was well-received according to the evaluation report completed by those in attendance.

6. The Chairman presented concerns of the North Carolina Medical Society at a hearing on the Human Tissue Study Committee of the Legislative Research Commission.
7. Dr. William Burch, committee member, actively served in an advisory capacity to radio programs initiated by Health Care Information, Inc.
8. The Committee prepared a comprehensive policy statement on the Public Relations Program of the Medical Society that was accepted by the Executive Council of the Medical Society. The recommendations in the policy statement are in the process of implementation.

A follow-up meeting of the Committee is planned for April 5, 1975.

Appreciation is expressed to the members of the Committee, President Frank Reynolds, Mr. William Hilliard, Mr. Gene Sauls, Mr. John Evenson, Mrs. Jackie Cutrell and others for the help given in the performance of the activities of the Public Relations Committee. The chairman is indebted to these fine folk for the progress of the Committee.

In related Committee on Public Relations activities, Health Care Information, Inc., the producer of a program entitled "For Your Health's Sake" and reviewed by Dr. William Burch, a member of the committee, is servicing a distribution list of 30 radio stations across North Carolina. Portions of several programs have been included on North Carolina News Network public service program run daily from coast to coast in North Carolina. Health Care Information, Inc., is operating under a grant from the Kate B. Reynolds Foundation.

MEDIX, an Emmy award winning television program produced by the Los Angeles County Medical Association and syndicated nationally by Burroughs Wellcome Company in cooperation with state medical societies, has achieved coast to coast airing in North Carolina. The stations involved include WECT-TV in Wilmington, WNCT-TV in Greenville, WGHP-TV in High Point, WSOC-TV in Charlotte and WFBC-TV in Greenville, S. C.

John L. McCain, M.D., Chairman

COMMITTEE ON RADIATION

Report not received March 20, 1975.

COMMITTEE ON RELATIVE VALUE STUDY

Report not received March 20, 1975.

RETIREMENT SAVINGS PLAN COMMITTEE

During the calendar year 1974 the Committee on Retirement Savings met at the conclave at Mid Pines in September. All the members were present and the committee received a report from Mr. Burkart of the Wachovia Bank & Trust Company relative to the plan's operation during the first three quarters of the year.

The principal matters were naturally related to the marked changes in value of common stocks and the change in the legal provisions of the "Keogh Law". It was our con-

census that there really existed no medium of investment which could offer a better potential than equities in basically sound industries over a protracted period and that the trustee was exercising reasonable care in its selection and timing of such purchases.

The amendment permitting self-employed persons to put aside an increased percentage of current income exempt from income tax was passed shortly after the committee's meeting. It was felt that this provision should make the society's plan more attractive to a greater number of members.

Under the provisions of the trustee's agreement with the society, the committee approved the appointment of Peat, Marwick, Mitchell & Company of Greensboro, N.C. as auditors for the participants of the plan for the next year.

The first and only chairman of this committee then announced his wish to relinquish the chair and your present reporter was elected in his stead.

Robert W. Williams, M.D., Chairman

COMMITTEE ON TRAFFIC SAFETY

Report not received March 20, 1975.

AD HOC STUDY COMMITTEE ON FEES

Report not received March 20, 1975.

COMMITTEE ON SOCIAL SERVICE PROGRAMS

The Committee met at Mid Pines on September 28, 1974, for its only meeting of the year. Meeting with the Committee were Dr. George A. Watson and Mr. Emmett L. Sellers of the Division of Social Services.

The Committee went on record as recommending that the North Carolina Medical Society disseminate to all physicians the following information: Consistent with the federal statutes, the implementing regulations and state law, along with the constraints of state budget policy, the North Carolina Medical Society recognizes that the basic purpose of the Medicaid program is to provide *necessary* health care to recipients of the program. The Society believes that "necessary" health care is not generally synonymous with "comprehensive" health care to every individual presenting himself for service. The concept of "necessary" care does not preclude quality care, to the extent that the presenting problem indicates prolonged examination and appropriately indicated consultations, laboratory tests, x-rays and injections. However, patients requiring these more extensive procedures should be the exception and not the general rule. The Society believes that it is a proper function of the Department of Social Services to require justification of medical necessity in selected claims, as indicated, by requesting documentation, on-site review, telephone inquiry and other means, and to then determine whether or not the services billed for fall within the bounds of "medical necessity" as understood by practicing physicians. In the event of the denial of a claim, the payment of which the physician after review still feels should be paid, a clearly delineated and available method of appeal, including peer physician consideration, must be available and functioning.

J. S. Mitchener, Jr., M.D., Chairman

COMMITTEE ADVISORY TO MEDICAL STUDENTS

Report not received March 20, 1975.

NORTH CAROLINA BOARD OF MEDICAL EXAMINERS

STATISTICS

November 1, 1973 - October 31, 1974

Total number of applicants granted license: . . .	745
By endorsement of credentials:	583
By written examination:	162
Examination failures (FLEX):	52
Limited licenses:	81
Hospital residents:	4
Counties:	77
Resident's training licenses:	302
Applicants rejected license by endorsement — (Did not meet Board requirements):	1
Applicants declined permission to take written examination:	2
Interviews:	33
Drug Addiction:	2
Mishandling of drugs:	11
Routine follow-up:	12
Petitioning for reinstatement of DEA registration: Declined reinstatement:	3
Approved reinstatement:	2
Other:	3
Requested to surrender all or part of DEA registration:	5
License to practice medicine revoked: 1	
License to practice medicine revoked; revocation stayed:	3
License to practice medicine voluntarily surrendered:	1
License to practice medicine reinstated:	0
Investigations:	41

NORTH CAROLINA MEDICAL CARE COMMISSION

During 1974, 21 medical facility projects receiving State and Federal aid were underway. Total cost for these projects is \$107.5 million; they will provide 1,055 additional beds. The 21 projects involved 11 hospitals, 3 extended care facilities, 1 mental health center, 1 facility for the mentally retarded, 2 rehabilitation facilities and 3 public health centers. In addition to these, the Construction Section has been readying during the year 5 other health facility projects, estimated to cost more than \$25.3 million that can be initiated when and if Federal appropriations are released. *North Carolina ranks second among all the states in the number of health facility projects constructed under the Hill-Burton Act.*

Scholarships for Medical and Related Health Studies

Recipients of the Division's educational loans agree upon completion of their training to repay their loans by one calendar year of service for each year they received funds. In 1974, 492 applicants were approved. The year's new participants bring the current in-school total to 771. An additional 179 recipients are in a deferred status (postgraduate training, military service or sick leave) providing a potential manpower contribution of 950. Of the 950, 307 are in nursing, 293 are in medicine, and 136 are in dentistry. During 1974, 229 recipients entered practice arrangements consistent with the needs of the State, making a total of 354 practitioners currently providing service in 14 different health professions. Five of those begin-

ning practice this year were physicians while fifteen dentists entered medically deprived areas.

Physician Recruitment

The pilot program to attract more physicians to rural practices authorized by the 1973 Legislature was designed to approach placement both by direct recruitment and by encouraging residents to gain field experience in rural communities. Financial assistance was planned to assist the community with costs involved in physician recruitment and to provide stipends for residents in rural areas.

In 1974 the program was placed under the aegis of the Office of Rural Health Services. During the calendar year, six residents seriously considering locating in North Carolina were assisted in qualifying field experiences. The recruitment effort has recruited eight physicians. Of the eight, six have already located and two will locate in 1975. Staff members of the Office of Rural Health Services are currently working to assist twenty-one communities in their continuing efforts to attract physicians.

Hospital Licensure and Medicare Certification

At the beginning of 1974 there were 153 licensed hospitals involving 22,781 beds which were licensed under General Statute 131, Article 13A. Before the end of the year there was a merging of two hospitals with no essential changing of beds. However, this reduced the number of licensed hospitals to 152. Many of these hospitals received consultation to assist them in retaining eligibility to admit patients under the Medicare and Medicaid programs. The number of hospital beds participating in the Medicare-Medicaid programs and thus meeting Federal standards is approximately 97% of the total in operation.

Emergency Medical Services

The 1974 General Assembly authorized the Medical Care Commission to (1) adopt sanitation standards for ambulances, (2) alter the minimum equipment list for ambulances, and (3) adopt regulations on qualifications for ambulance attendants. The Commission is expected to adopt new rules and regulations for ambulances early in 1975.

Name Change

Through the 1973 Organization Act, the Medical Care Commission became the Commission for Medical Facility Services and Licensure. The name was changed back to the North Carolina Medical Care Commission by the 1974 Legislature. Administrative support to the Commission continues to be provided by the Division of Facility Services, a unit of the Department of Human Resources.

I. O. Wilkerson, Jr., Executive Secretary

Executive Council

Summary of Minutes of Meetings of the Executive Council

NOTE: As recommended by the Finance Committee, the Executive Council authorized that just the salient actions of the Executive Council will be reported in brief form.

The verbatim transcript of the Executive Council minutes are on file in the Headquarters Office and may be reviewed or pertinent portions excerpted on request.

FALL EXECUTIVE COUNCIL MEETING

September 29, 1974

(Morning Session)

—The Fall meeting of the Executive Council convened at 9:10 a.m. in the Meeting House of the Mid Pines Club, Southern Pines, N. C., Dr. Frank R. Reynolds, President, presiding. Fifth District Councilor, Dr. Albert Stewart, Jr., gave the invocation, following which Dr. Reynolds recognized the new Vice Presidents Drs. Jack Hughes and Frank Sohmer, Jr. In addition, he introduced Dr. J. Kempton Jones as the new Sixth District Councilor, Dr. Bernard A. Wansker as the new Chairman of the Professional Service Commission and Dr. John H. Felts, Editor, *North Carolina Medical Journal*.

Following the introductions, Secretary, Dr. E. Harvey Estes, Jr., called the roll and declared a quorum present.

—Mrs. J. Benjamin Warren, representing the Auxiliary President, Mrs. Philip E. Russell, presented a brief report of the Auxiliary activities of the year.

—The Professional Insurance Committee presented two recommendations as follows: (1) The Professional Insurance Committee of the North Carolina Medical Society recommends to the Executive Council that it should approve an 82.3 per cent increase in the professional liability insurance program; and (2) The Society retain at the Medical Society's expense, the insurance actuary in Atlanta (Mr. John Glenn) to advise the Society as to the validity of the St. Paul Insurance Company's request for a rate increase, contingent upon the Society getting an acceptable estimate of his fee.

Following a presentation by St. Paul Company representatives and a report of the opinion of the private actuary, Mr. John Glenn, the Executive Council approved the 82.3 per cent rate increase and approved the employment of Mr. Glenn to be utilized at the President's discretion in dealing with the insurance problem.

—Dr. T. Tilghman Herring, Chairman, Committee on Finance, presented the proposed Budget for 1974 as estimated, as a balanced budget, which was approved and adopted by the Executive Council. See separate **REPORT A — REPORT OF THE EXECUTIVE COUNCIL**, Page 51, **HOUSE OF DELEGATES**, May 1, 1975.

—Approval was voted for the purchase of a house and lot adjacent to the Medical Society parking area and fronting on Bloodworth Street, on recommendation of the Chairman of the Committee on Finance. The property identified as the Partin property to be purchased at a cost of \$17,500.

—The Chairman of the Public Service Commission, Dr. Bernard A. Wansker, presented a recommendation for the Chairman and members of the Committee on Blue Shield to be appointed by the President for one year terms subject to reappointment to up to five con-

tiguous terms; and that an ad hoc committee be appointed to consider the relationship between the Medical Society and the North Carolina Blue Cross and Blue Shield corporation and report back at the Council Meeting just prior to the May 1975 session of the House of Delegates. After considerable discussion, the Council approved a motion that these matters be referred to the Blue Shield Committee with a request that they report to the Council at its next meeting on their recommendations.

(Afternoon Session)

—The Council on Review and Development proposed that the Committee on Medical Education be assigned to the Annual Convention Commission and that the Commission be changed to Annual Convention and Education Commission.

The Council on Review and Development also proposed that the Committee on Arrangements and the proposed that the Committee on Arrangements and the Committee on Programs for General Sessions be combined. The Council voted approval of the proposals, and a later motion was approved referring these matters to the Committee on Constitution and Bylaws.

—As information, the Council received a report from Dr. Frank Sohmer, Jr., President of the North Carolina Medical Peer Review Foundation, Inc. He indicated that since his last report the Foundation had signed a contract with HEW for over \$97,000 as a State Support Center to function in support of the eight PSRO areas designated by HEW, and Dr. Sohmer also briefly outlined activities underway in each of the PSRO areas of the state. The employment of Mr. Otto Mueller as a program director was announced and also added that if the Foundation went into the second portion of its program then it will involve an additional \$112,000 grant from HEW. In addition, he said, the Foundation is negotiating with the N. C. Department of Human Resources to develop a quality module for the Medicaid management information system.

—The Executive Council named the following physicians to membership on the Committee on Blue Shield as a result of vacancies created by the establishment of new specialty sections: Dr. John W. Foust of Charlotte, Section on Otolaryngology, term expiring in 1977; Dr. George T. Thornhill of Raleigh, Section on Ophthalmology, term expiring in 1977; Dr. Robert L. Timmons of Greenville, and Dr. David L. Kelly, Jr., of Winston-Salem, Section on Neurosurgery, Dr. Timmons' term expiring in 1976 and Dr. Kelly's term expiring in 1977.

—The Executive Council appointed Dr. Bernard A. Wansker of Charlotte to fill the unexpired term of the late Dr. Leonard Palumbo, Jr., on the Retirement Sav-

ings Plan Committee, the term expiring in 1975.

—A recommendation from the Section on Neurology and Psychiatry urging that the Director of the Division of Mental Health Services be appointed to the Executive Council in a similar capacity to that of the Director of the Division of Health Services was postponed until the next meeting, pending research as to whether the State Statutes required the Director of the Division of Mental Health Services to be an M.D.

—The committee on Disaster and Emergency Medical Care submitted a report summarizing the State Program of Emergency Medical Services established in the Department of Human Resources and requested the support of the Society in its implementation. Following brief discussion the report was approved. See separate REPORT B — REPORT OF THE EXECUTIVE COUNCIL, Page 55, HOUSE OF DELEGATES, May 1, 1975.

—As information, the Committee on Eye Care and Eye Bank reported that there exists a great disparity between reimbursement rendered by optometrists and ophthalmologists with the committee recommending that appropriate corrective legislation be prepared. A sub-committee is investigating the best approach to proposing a change for further consideration by the Committee.

—The Executive Council voted to postpone action on a recommendation from the Committee on Eye Care and Eye Bank concerning a need for more qualified people to enucleate eyes, to be accomplished by expanding the list of persons authorized to perform the procedure. The Council's decision was based on the concern about the lack of clear definition in the proposal of the qualifications of the persons listed in the proposal.

Later in the meeting and on reconsideration because of the need for some guidance being given to the Committee on Legislation, the Council approved a motion that the Council direct the Society Legal Council to advise the legislative group the Society's desire to define in the law that the patient must be pronounced dead by a physician before a physician's assistant, a registered nurse, or an embalmer be allowed to remove an eye.

—The Committee on Eye Care and Eye Bank recommended and the Council approved the recommendation that since the purpose of the N. C. Blind Clinics is to detect and treat diseases of the eye they should be staffed only by ophthalmologists and that a copy of this opinion be forwarded to the Department of Human Resources, to the Advisory Committee to the Blind Commission and to all members of the State Blind Commission.

—As information, the Committee on Legislation reported on plans to hold a Practical Politics Seminar at Appalachian Center for Continuing Education in Boone, September 12-14, 1975, in cooperation with Smith, Kline & French Laboratories. It was also reported that the Committee on Legislation was planning to have a reception for Legislators sometime early in 1975 and that the Committee plans to prepare a legislative issues.

—The Executive Council approved the proposal that the Society extend the AMA Council on Legislation an invitation to hold one of its regular meetings at the Society headquarters building in Raleigh.

—As information, the Committee on Public Relations announced the January 31 and February 1, 1975, dates

for the Annual Conference for Medical Leadership and encouraged members of the Council to attend and solicited the assistance of the members in encouraging members of the respective county medical societies to attend.

—After considerable discussion the Executive Council voted disapproval of the joint proposal from the Committee on Blue Shield and the Insurance Industry Committee that the Committee on Peer Review meet quarterly to receive referred cases from the other North Carolina Medical Society Committees that are engaged in claims review; that the Peer Review Committee be of sufficient size and avail itself of sufficient consultants to attempt to educate those identified as "problem" physicians. It was further proposed that to support this effort, the committee should request adequate funding and staffing from the Society.

—The Council approved a recommendation from the Committee Advisory to the Crippled Children's Program that the program be asked to allow a non-certified orthotist or prosthetist to be available to orthopaedists in outlying areas without themselves being certified if they're associated with a certified shop. Further that the technical institutes, community colleges and the state university system be encouraged to institute new programs and be responsible for increasing their training programs for orthotists and prosthetists.

—The Committee Advisory to the Crippled Children's Program proposed that it be recommended to the Crippled Children's Program that in outlying areas, away from the medical centers, that a team leader in the person of a pediatrician be utilized in a team approach in the handling of children with cleft lip and/or palate cases so that proper coordination of services could be assured and that such team leader be paid for his services. While the Council did not pass a specific motion on this subject, the entire report of the Commissioner presenting the report for the Committee was approved, and the sentiment of the discussion did seem to favor the proposal.

—The Executive Council referred back to the Committee on Physical and Vocational Rehabilitation for further definition, including a budget, the Committee's recommendation that the Society sponsor a conference on psychiatry as it relates to the severely disabled and second, that the Society organize a meeting of the deans and directors of the rehabilitation centers along with the Society Committee on Physical and Vocational Rehabilitation for the purpose of pursuing the development of training programs in rehabilitation medicine.

—The ad hoc Study Committee on Fees presented a recommendation relating to a bill introduced in the last session of the General Assembly which would have required all insurance carriers to reimburse for physicians' services on the basis of a statewide calculation of Usual, Customary, and Reasonable charges. After considerable discussion the Executive Council approved a substitute motion to the effect that the North Carolina Medical Society opposes the legislative intention to require all commercial insurance companies in North Carolina to reimburse physicians' fees on a statewide basis of usual, customary and reasonable unless the bill provides that in no event shall the insurance company which issued the policy be liable for the reimbursement to the policyholder of any amount less than the reasonable charge for the services actually rendered at the time and place they were rendered.

—The Executive Council approved a recommendation

from the ad hoc Study Committee on Fees that the Society strongly urges support of one hundred percent reimbursement of usual, customary and reasonable fees in the Medicaid program in lieu of the present practice of reimbursing only ninety percent of usual, customary and reasonable under Medicaid. See separate REPORT C — REPORT OF THE EXECUTIVE COUNCIL, Page 55, HOUSE OF DELEGATES, May 1, 1975.

—Based on a recommendation from the Committee on Allied Health Professions and after considerable discussion, the Executive Council approved a substitute motion that the President annually appoint eight physicians as representatives to the Joint Practice Committee, such committee members to include the Chairman of the Committee on Allied Health Professionals, and such committee to report periodically on the actions of the Joint Practice Committee to the Executive Council of the Medical Society.

—The Committee on Constitution and Bylaws recommended a change in wording in the Constitution of the description of the rights and privileges of Intern-Resident Training Members. This proposed change does not involve any change in rights and privileges, only a change in descriptive words. See separate REPORT D —REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 55 & 63 & 75, HOUSE OF DELEGATES, May 1, 1975.

—The Executive Council approved a recommendation that a resolution from the Council be sent to Dr. Jesse Caldwell expressing thanks and appreciation for his good faithful service to the Society as Chairman of the Retirement Savings Plan Committee, upon the occasion of Dr. Caldwell's resignation as Committee Chairman.

—The Council appointed Dr. Robert C. Moffatt of Asheville, Chairman of the Medical Society Committee on Comprehensive Health Service Planning as the Society's representative to attend a meeting of Task Force of the Governor's Advisory Council on Comprehensive Health Planning on October 29, 1974, in Raleigh.

—The Executive Council accepted as information a report from the Committee on Comprehensive Health Service Planning on "The Physician and Comprehensive Health Planning" and approved a recommendation that the report be mailed to all members.

—The Council accepted a Preliminary Report of the Henderson County Consumer Health Survey of the Mountain Ramparts Health Planning.

—Approval was voted for a recommendation from the Committee on Social Service Programs that information be distributed to the membership about the provisions of the law pertaining to services under the Medicaid program as it relates to the terms "necessary" care and "comprehensive" care in an effort toward better understanding by physicians of the extent of carrier liability under the program and what is the intent of the law.

—The Committee on Chronic Illness recommended and the Council approved of the proposal that the Red Cross devise means of its own choosing to properly refer hypertensives to suitable medical authorities whenever Red Cross representatives in blood banks run across such problems in the course of taking blood pressures.

—The Council approved a recommendation from the Committee on Chronic Illness for the approval of the use of prophylactic treatment of tuberculosis in

North Carolina so as to conform with the standards of the Center for Disease Control of the U. S. Public Health Department. See separate REPORT E — REPORT OF THE EXECUTIVE COUNCIL, Page 55, HOUSE OF DELEGATES, May 1, 1975.

—Approval was voted for the appointment of two representatives of the Mental Health Committee or of the Medical Society to serve with those seeking to make a grant application entitled "PSRO Model, Utilization Review Procedures for Community Mental Health Centers," in its planning phase.

—The Committee on Mental Health recommended that the Medical Society take notice of what they regard as one of the many unconstitutional points in the Commitment Law and that this sentence in the law be changed or rephrased so that private physicians are not bypassed. The sentence says: "All patients being committed must be referred to the mental health system." The Committee feels that commitment proceedings should be done by a private psychiatrist as well as a public psychiatrist in order not to infringe on the private practice of psychiatry. The Council voted that the principle be accepted and be referred to the Legislative Committee to work out in conjunction with the Committee on Mental Health.

—It was approved on the recommendation of the Committee on Mental Health that the Medical Society encourage the Governor to proclaim an Alcoholism Awareness Week in North Carolina and support the proposal with a letter from the President of the Society to the Governor.

—The Council approved the Committee on Mental Health recommendation that the Medical Society support the surcharge on beer and wine to help support the Alcoholic Research Authority.

—The Committee on Drug Abuse presented a resolution relating to reporting an M.D. for suspected drug abuse to the North Carolina Board of Medical Examiners, with the resolution being approved by the Council. See separate REPORT F — REPORT OF THE EXECUTIVE COUNCIL, Page 58, HOUSE OF DELEGATES, May 1, 1975.

—The Committee on Occupational and Environmental Health presented a series of recommendations designed to make physicians in North Carolina more fully aware of the common hazards in the working environments of their patients and generally to promote the Society providing the widest possible dissemination of information on occupational health and safety items. The report was accepted with the condition that it makes no impact on the current previously approved budget. See separate REPORT G — REPORT OF THE EXECUTIVE COUNCIL, Page 59, HOUSE OF DELEGATES, May 1, 1975.

—Taking note of the fact that members of the Nominating Committee must be Delegates at the time of their election to the Nominating Committee and of the fact that the term of election to the Committee is for three years, the Executive Council as the authorized interpreter of the Constitution and Bylaws ruled that the members of the Nominating Committee should continue throughout their term to which elected even though they might not continue to be a delegate.

—A motion of support for the development of a School of Veterinary Medicine in North Carolina was approved by the Executive Council.

MID-WINTER EXECUTIVE COUNCIL MEETING

February 2, 1975

(Morning Session)

—The Mid-Winter Meeting of the Executive Council convened at 9:06 a.m. in the Executive Council Room of the Medical Society Building, Raleigh, N. C., President Frank R. Reynolds presiding. Third District Councilor E. Thomas Marshburn, gave the invocation, and Secretary E. Harvey Estes, Jr., called the roll declaring a quorum present.

—The request of the Section on Neurology and Psychiatry for the Director of the Division of Mental Health Services be appointed to the Executive Council in a similar capacity to that of the Division of Health Services, which is ex officio, was reconsidered after the request was postponed during the September 29, 1974, meeting of the Executive Council.

After brief discussion the Executive Council approved a motion that the request be postponed for one year, but that in the meantime the Director of the Division of Mental Health Services be invited to attend the meetings of the Executive Council and that he be given the privilege of the floor for that period of time.

—Dr. Archie T. Johnson, Jr., reported on principle provisions of the recently passed Public Law 93-641

—The National Health Planning and Resources Development Act of 1974 and stated that the Governor and the Secretary of Human Resources were interested in the Medical Society expressing its recommendations on those provisions of the act which provided for Governors to submit recommendations to the Department of H.E.W. Following his report, President Reynolds read a letter from Secretary of Human Resources, David T. Flaherty offering the Medical Society an opportunity to submit its concept of how best to accomplish the tasks called for under the Act, such recommendations requested to be submitted by February 17, 1975.

After considerable discussion, the Executive Council approved a motion that the President appoint an ad hoc Committee to develop a plan for recommendation of the Council.

—Dr. T. Tilghman Herring, Chairman, Committee on Finance, reported that International Developers, Inc., the purchaser of the Medical Society Airport Highway property, had failed to make the regular quarterly payment due in December. He indicated that he had been in touch with the owners who had indicated that there was no money to make the payment at this time. Following discussion, the Executive Council approved a motion that the Committee on Finance notify the International Developers, Inc., in writing of their deficiency in meeting their payments.

—Dr. T. Tilghman Herring, reporting for the Committee on Finance presented the Annual Audit for the 1974 calendar year. He reported that taking into consideration the purchase of two houses and lots adjacent to the Medical Society parking lot being paid for out of current operating funds in 1974, which are considered as capital additions, then the Society operated some \$28,000 in the black in 1974. See the Compilation of Annual Reports for details of the Auditor's Report.

—The Executive Council reconsidered a request from the American Medical Association that whenever possible the State Medical Society sponsor one or two House Officers (Intern and Resident) to accompany the

delegation to both the annual and clinical conventions of the AMA. After brief discussion of budgetary needs and problems of selection of such representatives, the Executive Council approved a motion that the Society not sponsor intern and resident house officers to the AMA conventions.

—The Executive Council approved the outright purchase of a new photocopy machine, at an estimated cost of \$5,695, as opposed to rental or rental purchase agreement, and explained the savings to the Society over several years. Authorization to purchase the Equipment was voted by the Executive Council in excess of the year's anticipated budget for regular equipment purchases.

—Dr. Bernard A. Wansker, as commissioner, reported on recommendations from the Committee on Blue Shield on matters referred to that Committee by the Executive Council from the last Council meeting and relating to a proposed restructuring of the Committee on Blue Shield. After making slight changes in the wording, the Council approved the recommendation which would in effect make the Committee subject to appointment by the President rather than elected by the House of Delegates. See separate REPORT H — REPORT OF THE EXECUTIVE COUNCIL, Page 59, HOUSE OF DELEGATES, May 1, 1975.

—Dr. John L. McCain made a recommendation that the Executive Council consider the formation of an Inter-Specialty Council within the North Carolina Medical Society. After discussion, the Council approved a motion that the matter be referred to the Council on Review and Development for a recommendation to be brought back to the Council.

—Dr. H. David Bruton, Chairman, Committee on Legislation announced that a reception for Legislators would be held on Tuesday, April 8, 1975, and expressed the hope that all members of the Council would be present to make contact with the members of the General Assembly. He also announced plans for a Practical Politics Seminar in Boone, September 12-14, 1975, with the Executive Council and key contact physicians in each county being particularly invited.

—The Committee on Legislation recommended and the Executive Council approved to support the concept of a Bill in the General Assembly identified as H.B. 74, which would provide for the establishment of a Professional Liability Reinsurance Exchange.

—Approval was voted on recommendation of the Committee on Legislation to endorse in concept the legislation proposed by the Board of Medical Examiners that would amend the Medical Practice Act to require one year of postgraduate education for licensure providing the wording and regulations can be worked out to accommodate the first year of postgraduate training.

—The Executive Council supported the proposal from the Board of Medical Examiners, on recommendation of the Committee on Legislation, to amend the Medical Practice Act to empower the Board of Medical Examiners with subpoena power for doctor's medical records having to do with patient care and to have access to such records.

—The Executive Council tabled a proposal from the Board of Medical Examiners, to endorse and sup-

port an amendment to the Medical Practice Act to include "gross overcharging" in Section 90-14 of the General Statutes, the section which gives the Board the power to revoke and rescind any medical license.

(Afternoon Session)

—The Executive Council approved the recommendation of the Committee on Legislation to endorse legislation that would allow minors to give consent for various health services including mental illness, pregnancy, drug abuse, and venereal disease.

—The Council supported a proposed pilot program of comprehensive child screening for all four year olds in North Carolina.

—The Executive Council approved a motion to go on record as opposed to proposed legislation that would permit family nurse practitioners or physician's assistants to prescribe, compound, and dispense drugs.

—On the recommendation of the Committee on Legislation, a statement on acupuncture was approved as follows: "It is the conviction of the North Carolina Medical Society that acupuncture therapy should be regarded as the practice of medicine in an experimental phase permissible only in qualified investigational settings." See separate REPORT I — REPORT OF THE EXECUTIVE COUNCIL, Page 59, HOUSE OF DELEGATES, May 1, 1975.

—The Committee on Legislation reported that it had considered the many ramifications of the recommendations of the ad hoc Study Committee on Fees presented at the September 29, 1974, Executive Council meeting and was unable to agree on how the Society position should best be presented to the members of the General Assembly. The Committee in essence was requesting instructions on how to respond to legislation on the subject of statewide determination of usual, customary and reasonable fees whenever the proposition comes up in the Legislature. After considerable discussion, a motion to reaffirm the Executive Council action of September 29, 1974, was defeated. A following motion that the Executive Council go on record as supporting the concept of a statewide uniform method of determination of reimbursement was also defeated.

—Approval was voted by the Executive Council agreeing with the concept of support for proposed legislation that would allow the Board of Medical Examiners to reimburse members of the Board for all actual expenses incurred in the performance of their duties on the Board.

—The Executive Council approved in concept, support for proposed legislation which would provide an appropriation of \$250,000 to be available to the Medical Schools in North Carolina for support of a program of primary care clerkships for medical students in an effort to provide practice opportunities in primary care in medical schools.

—Dr. M. Frank Sohmer, Jr., reported briefly for the North Carolina Medical Peer Review Foundation of three principal areas of current Foundation activity:

He reported that the nursing home review contract the Foundation has with the Department of Human Resources to carry out review of all Medicaid patients in nursing homes, psychiatric hospitals and tuberculosis sanatoria across the state was to have run out on March 28, 1975, but has been extended by the Department until December 31, 1975.

In July of 1974, the Foundation contracted with

H.E.W. as a support Center for North Carolina under the PSRO legislation. In the eight PSRO designated areas in North Carolina, one area already has a contract with H.E.W. as a planning grant operation, and has made application to H.E.W. to become a conditional operational PSRO for its Area II—a twelve county area. By the time grant applications are due in the spring, the seven other PSRO areas might be in a position to submit a dual grant application, that is, for all seven areas to present a planning grant application and a conditional grant application.

The third part of the Foundation program has to do with the Utilization Review regulations of November 29, 1974, put forth to cover review of Title 18 — Medicare and Title 19 — Medicaid, with an implementation date of February 1, 1975, on these UR regulations. The Foundation has a contract with the Department of Human Resources to implement a statewide review program of 151 hospitals by June 1, 1975, for what is called Hospital Admission Review Program (HARP).

—The Executive Council voted to refer to the appropriate committee for consideration and presentation to the House of Delegates in May the request for Jones County to be removed from the Lenoir-Greene-Jones County Medical Society and joined with the Craven-Pamlico County Medical Society to become the Craven-Pamlico-Jones County Medical Society. See separate REPORT J—REPORT OF THE EXECUTIVE COUNCIL, Page 59, HOUSE OF DELEGATES, May 1, 1975.

—Appointment of an ad hoc Committee to Study the Professional Liability Insurance Problem in the State was approved by the Executive Council.

—A request was received by the Executive Council from the North Carolina Chapter of the American College of Emergency Physicians that a Specialty Section on Emergency Medicine be formed within the State Society. After considerable discussion, and after being advised of the American Academy of Family Physicians recommendation to the Member Organizations of the Council of Medical Specialty Societies that no primary board of emergency medicine be established at this time, the Executive Council approved a substitute motion that the matter be tabled indefinitely with the idea that it could come up at the next Executive Council meeting. It seemed to be the consensus of the Council that while there was no opposition to the establishment of a new specialty section of the Society it appeared that emergency medicine had not yet evolved to the degree to warrant recognition as an exclusive specialty.

—Dr. John L. McCain, Chairman, Committee on Public Relations, presented a suggested Public Relations Policy Statement, with a motion for acceptance being passed by the Executive Council. See separate REPORT K — REPORT OF THE EXECUTIVE COUNCIL, Page 59, HOUSE OF DELEGATES, May 1, 1975.

—The Committee on Traffic Safety recommended and the Executive Council approved that the Society endorse proposed legislation calling for mandatory seat belt usage in North Carolina.

—Consideration was given by the Executive Council of a proposed statewide scoliosis screening program for school children under State direction. After discussion the proposal was postponed until the Council could

receive a recommendation from the Section on Orthopaedics.

—Approval was given for the promotion of a travel opportunity for Medical Society members to attend the AMA Clinical Session in Hawaii, November 28 to December 6, 1975, at a special group travel rate.

—The Executive Council approved a motion that it

is the policy of the Society not to recommend or support meetings which are sponsored by individuals, rather than groups.

—The Council agreed by general consensus that the next meeting of the Executive Council would be held on April 13, 1975, approximately two weeks before the Annual Meeting of the Society.

ANNUAL EXECUTIVE COUNCIL MEETING

April 13, 1975

(Morning Session)

—The Annual Meeting of the Executive Council convened at approximately 9:00 a.m. in the Executive Council Room of the Medical Society Building, Raleigh, N. C., President Frank R. Reynolds, M.D., presiding. President-Elect, James E. Davis, M.D., gave the invocation, and the Secretary, E. Harvey Estes, Jr., M.D., called the roll and declared a quorum present.

—The Executive Council reconsidered the question of the proposal to change the N. C. General Statutes to permit nurses or physician's assistants to prescribe, compound and dispense drugs under direction and supervision of a physician. After discussion, approval was voted on a motion to accept the revised draft of the proposal to amend the Medical Practice Act. See separate REPORT L — REPORT OF THE EXECUTIVE COUNCIL, Page 61, HOUSE OF DELEGATES, May 1, 1975.

—Dr. Edgar T. Beddingfield, Jr., Chairman, Committee on Traffic Safety, presented a series of recommendations relating to recommendations for standards for visual fields for drivers, creating a classified driver's licensing system, favoring a supplemental budget request to support the breathalyzer program, and for making a patient's driving records a part of the information supplied a physicians when evaluating a patient's ability to drive. The recommendations were approved by the Executive Council. See separate REPORT M — REPORT OF THE EXECUTIVE COUNCIL, Page 61, HOUSE OF DELEGATES, May 1, 1975.

—The Executive Council approved several recommendations from the ad hoc Committee to Study Professional Liability Insurance Problems, presented by Dr. John Glasson for the Committee. See separate REPORT N — REPORT OF THE EXECUTIVE COUNCIL, Page 62, HOUSE OF DELEGATES, May 1, 1975.

—As information, the Executive Council received a report from Mr. Keith Bulla, Supervisor, Diversion Investigative Unit, North Carolina State Bureau of Investigation, concerning the guidelines followed by the SBI in making recent investigations and several arrests of physicians in the State for violation of drug dispensing practices.

—Dr. Charles B. Wilkerson, Jr., Secretary, Board of Medical Examiners reported as information the selection by the Board of Dr. Bryant L. Galusha to fill the vacancy on the Board created by the resignation of Dr. Jack Powell, explaining that State Statutes provide for the Board to fill such vacancies. The Board was requested to study the process of selection of members to the Board and report back to the Executive Council.

—Dr. Charles W. Styron, Chairman, ad hoc Committee to Study & Make Recommendations Regarding P. L. 93-641—National Health Planning and Resources

Development Act of 1974, reported as information that the Committee had studied the law and made recommendations for the geographic designation of two Health Service Areas within North Carolina.

—It was reported for the Committee on Finance, that the purchaser of the Medical Society Airport Highway property, had still not made any payment on the amount due and in arrears on the purchase, with the Council suggesting that the matter be placed on the agenda for the next meeting for a report.

—An information report was made on a zoning proposal before the Raleigh City Council pertaining to making the area including the Medical Society building and property in a proposed Historical District and the fact that the Society had requested exemption from inclusion in the Historical District.

(Afternoon Session)

—The Executive Council accepted, for referral to the House of Delegates, a Resolution submitted by the Committee on Medical Education resolving that the North Carolina Medical Society apply to the Council on Medical Education of the American Medical Association for recognition as a body approved to accredit programs of continuing medical education in North Carolina. See separate RESOLUTION: 12, Page 65, HOUSE OF DELEGATES, May 1, 1975.

—Dr. A. L. Chasson, Chairman, Committee on Medical Education, presented a report for the Committee in response to the request of the May 1974 House of Delegates that the Committee study and recommend methods of awarding credits, processing and recording replies, managing cases of hardship and noncompliance and to report their findings to the House of Delegates in 1975. The Executive Council accepted the report for forwarding to the House of Delegates. See separate REPORT O — REPORT OF THE EXECUTIVE COUNCIL, Page 62, HOUSE OF DELEGATES, May 1, 1975.

—Nominees for the North Carolina MedPac Board of Directors were received and the following were elected:

Edgar T. Beddingfield, Jr., Md.
Kenneth Cosgrove, M.D.
John T. Dees, M.D.
James E. Davis, M.D.
Ledyard DeCamp, M.D.
R. Spencer Eaves, Jr., M.D.
John H. Hall, M.D.
Charles Hoffman, M.D.
T. Reginald Harris, M.D.
Archie T. Johnson, M.D.
David Nelson, M.D.
Marshall S. Redding, M.D.

Robert H. Shackelford, M.D.
John W. Watson, M.D.
H. David Bruton, M.D.

Auxiliary

Mrs. A. J. Crutchfield
Mrs. Edna Hoffman

—The Executive Council accepted with great regret the resignation of Dr. Donald B. Koonce of Wilmington as a Delegate to the American Medical Association and expressed appreciation for his service to the Society, unanimously adopting an expression of appreciation. See separate REPORT P—REPORT OF THE EXECUTIVE COUNCIL, Page 62, HOUSE OF DELEGATES, May 1, 1975.

—The Executive Council appointed Dr. James E. Davis of Durham to fill the unexpired term of Dr. Donald B. Koonce, created by the resignation of Dr. Koonce, a term expiring December 31, 1976.

—The Council reviewed a resolution on the subject of Chemical Screening Tests by Local or Area Health Departments, submitted by the Beaufort-Hyde-Martin-Washington-Tyrrell Counties Medical Society, received after the normal deadline for acceptance of resolutions by the Headquarters Office. A motion was approved that the Executive Council accept the resolution and send it to the House of Delegates as a report from the Council. See separate RESOLUTION: 13, Page 66, HOUSE OF DELEGATES, May 1, 1975.

—Dr. Louis Shaffner, Chairman, Committee on Constitution and Bylaws presented a Report of the Committee on Constitution and Bylaws, which was accepted for referral to the House of Delegates. See separate REPORT Q—REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 75, HOUSE OF DELEGATES, May 1, 1975.

—Dr. John Glasson, reported as information for the Executive Council, that the Delegates to the AMA had met in keeping with the provisions of the Constitution and Bylaws and elected Dr. David G. Welton of Charlotte, the Senior Delegate, to be the Chairman of the Delegation.

—The Council reviewed the lettered reports "A" through "K" as contained in the delegates kits which were accepted for referral to the House of Delegates, all having been developed on the basis of previous Council actions.

—The Council reviewed the numbered Resolutions I through 11 and approved that they be accepted for referral to the House of Delegates as presented and for referral to the Reference Committees to which they have been assigned.

—As information, the Council received a report from Dr. Frank Sohmer, Jr., President of the North Carolina Medical Peer Review Foundation, Inc., briefly outlined activities underway through the Foundation, and describing contracts being negotiated with the State Department of Human Resources and with Health Applications Systems for the peer review responsibility under the State Medicaid Program. He also reviewed the estimated percentage of physicians participating in the Medicaid Program.

Following Dr. Sohmer's presentation, the Executive Council approved a motion that the Executive Council requests that the House of Delegates take official action urging and requesting that all physicians participate in the North Carolina Medicaid Program. See separate REPORT R — REPORT OF THE EXECUTIVE COUNCIL, Page 63, HOUSE OF DELEGATES, May 1, 1975.

—The Executive Council received a report, as information, from the Committee on Public Relations growing out of a recent Committee meeting and relating to its plans that approximately one-half of the 1976 Leadership Conference time be devoted to small group discussion, to the suggested change of the *Public Relations Bulletin* name to *Insiders Bulletin*, and to a suggestion that the Committee explore the possibilities of putting on a "Quality of Life Symposium." The Committee also presented a Resolution on the subject of a "Suggested Position Paper on Patient Education" which was accepted by the Council for referral to the House of Delegates. See separate RESOLUTION: 14, Page 66, HOUSE OF DELEGATES, May 1, 1975.

—The Executive Council considered a request of the North Carolina Podiatry Society for a statement of policy on the question of extending hospital privileges to licensed Podiatrists, and approved a motion that this Council go on record as recognizing the validity of a hospital staff considering approval of the membership of a podiatrist on the staff of the hospital on an individual basis, with qualifications and functions in accord with published guidelines of the Joint Commission on Accreditation of Hospitals and the American Academy of Orthopaedic Surgeons. See separate REPORT S—REPORT OF THE EXECUTIVE COUNCIL, Page 63, HOUSE OF DELEGATES, May 1, 1975.

—Dr. E. Thomas Marshburn moved, and the Executive Council approved a Resolution extending President Frank R. Reynolds this Council's appreciation and thanks for a job well done as President of the Society and as Chairman of this Council for this year, since this was the last meeting of the Council over which Dr. Reynolds would preside. The membership of the Council gave Dr. Reynolds a round of applause in appreciation.

Abridged Minutes of the Meetings of the House of Delegates

FIRST SESSION

THURSDAY AFTERNOON SESSION

May 1, 1975

The First Meeting of the House of Delegates of the 121st Annual Meeting of the North Carolina Medical Society convened at two-six o'clock in the Cardinal Ballroom of The Pinehurst Hotel, Pinehurst, North Carolina.

DR. FRANK R. REYNOLDS [President of the Medical Society]: At this time I would like to call the 121st Annual Meeting of the North Carolina Medical Society to order.

It gives me a great deal of pleasure to turn over the gavel to your able, efficient Speaker of the House of Delegates, Dr. Chalmers Carr, from Charlotte, North Carolina.

DR. CHALMERS R. CARR [Speaker of the House of Delegates of the Medical Society]: Thank you, President Reynolds.

Welcome, members of the House of Delegates! Welcome, guests!

(The invocation was given by the Reverend Orion N. Hutchinson Jr of Greensboro.)

SPEAKER CARR: It's now my pleasant duty to introduce the officers of the Society.

(The Speaker introduced the officers as follows: President Frank R. Reynolds, Vice Speaker Henry J. Carr, First Vice President Jack Hughes, Second Vice President M. Frank Sohmer, Jr., Secretary E. Harvey Estes, Jr., President-Elect James E. Davis, and Parliamentarian Louis Shaffner, each standing to be recognized as he was introduced.)

My next and very pleasant duty is to introduce our President again, Frank Reynolds, who will make his opening remarks at the House of Delegates and his first speech of several during the session.

PRESIDENT REYNOLDS: Thank you, Dr. Carr. [Whereupon President Reynolds then read his prepared Message of the President to the House of Delegates as printed in North Carolina Medical Journal, Vol. 36, No. 7 (June) 1975, Page 397. At the conclusion of his presentation he was accorded a standing ovation.]

SPEAKER CARR: Thank you, President Reynolds, for that inspiring address, those timely suggestion.

MESSAGE OF THE PRESIDENT OF THE AUXILIARY

Dr. Reynolds, I'm going to ask you to do us the honor and the Society the honor to escort Mrs. Philip Russell, (Lou), to the podium for a report from the Auxiliary.

[Whereupon Mrs. Philip E. Russell was accorded a standing ovation, as she was escorted to the podium.]

MRS. PHILIP E. RUSSELL [Auxiliary to the North Carolina Medical Society]: Thank you, Frank, Dr. Carr, Dr. Reynolds, Members of the Society and Guests:

Your Auxiliary is 52 years old—that dangerous middle age! But, we've been too busy to worry about middle age depression.

We've been sponsoring V.D. workshops for teachers,

first aid courses for student drivers; we've furnished films and speakers on child abuse; we've manned blood mobiles; we've started hospital libraries and thousands of boys and girls in North Carolina have been exposed to health careers through our Health Fairs and our Health Museums.

We started our 51st year with a face lift!

We revised our constitution and our bylaws and then and uplift—we raised our dues!

Our middle aged spread has been confined to spreading into unorganized counties in North Carolina. Three unorganized counties have combined with a two-county auxiliary and now they are a 5-county component.

One unorganized county has reactivated. We have two counties who have elected officers and who are eager to start this summer. No emptiness syndrome for us!

And, our babies such as mental health research endowment and our sanatoria beds, as they became self-sufficient we found new babies! Child abuse, Health Education, Learning Disabilities.

One baby which we continue to nourish is AMA-ERF AND LOOK AT ITS REPORT CARD! \$16,700 last year and already we're over \$21,000 this year for student loans and unrestricted funds to medical schools.

We have an AMA-ERF booth and silent auction down the hall by the elevator and you can't miss it because it's got a poster with a bikini-clad babe on it!

So stop by and support AMA-ERF!

We channelled those "hot flashes" into putting heat on unmet needs in North Carolina.

Dr. Reynolds mentioned our health education survey and the results that we're getting from the Department of Public Instruction.

We also have worked for candidates. We've written letters. We've signed petitions and our AMPAC-MEDPAC membership is the highest in the history of the Auxiliary.

I don't have time to list all our activities. I hope you will read our annual report.

We're grateful to you, both individually and as a group, for your continued support.

We have not spent your money frivolously. We have spent it to coordinate the activities of over 2,850 dedicated doctors' wives, from 68 counties banded into 48 auxiliaries.

That takes a lot of workshops, training sessions, telephone calls, letters and personal visits. Always we are working to support your endeavors.

We want to show that physicians' wives are concerned and do care. We're proud to be the Auxiliary to the North Carolina Medical Society. We hope you're proud of us.

[Whereupon the entire assemblage then accorded Mrs. Russell a standing ovation.]

SPEAKER CARR: Thank you, very much, Mrs. Russell, for this kind message, inspirational talk and accounting of what your Auxiliary is doing for us.

We will now stand in recess for five minutes. Don't leave the room if you can prevent it.

[Whereupon there followed a ten minute recess.]

HOUSE OF DELEGATES

I will now hear from Dr. John Payne who will give us a report from the Credentials Committee as to the number registered and the number present in the House.

DR. JOHN A. PAYNE, III [Chairman, Credentials Committee]: Mr. Speaker, John Payne from Gates County!

We have 187 delegates registered, 176 delegates are seated. This 176 of a total of 187 represents a majority of the registered delegates, and constitutes a quorum.

SPEAKER CARR: I declare a quorum present. We are ready for business.

By special arrangements and on our agenda, the next message will be from Dr. William Hollister, Chairman of MEDPAC.

REPORT ON N. C. MEDPAC

DR. WILLIAM F. HOLLISTER [Chairman, North Carolina MEDPAC]: Mr. Speaker, Delegates and Guests:

On behalf of the North Carolina MEDPAC Board of Directors, I would like to thank you for this opportunity to briefly tell you about our activities.

We have had a most successful year. Our Directors all became sustaining members, that is each contributed \$100 or more for membership, which stimulated recruiting activities for further development of new membership.

I believe our success was largely due to this commitment by our Board members.

All of you should know by now that MEDPAC has won two membership awards from AMPAC for the 1974 year. We were placed nationally in the category of largest percentage increase in sustaining members and third, nationally, in the category of largest percentage increase in overall membership.

Needless to say, we are extremely proud of these awards and the hard work they represent.

I should like to compliment Mrs. Russell on the hard work that she and the Women's Auxiliary has done in increasing its membership in MEDPAC.

For this year for the first time we published a newsletter for our membership. It provided information about activities MEDPAC was engaged in and information of interest to membership, voting records, candidates support information and editorial messages were part of the newsletter.

A word of thanks is due our Director of Governmental Affairs, Steve Morrisette, for making this information available to all of you who are members of MEDPAC.

The MEDPAC Board at its last meeting approved a new constitution and bylaws which we think will increase the efficiency of our operations and the effectiveness of our organization.

I should like to thank Dr. John T. Dees of Burgaw and his committee who worked diligently at this task for almost a year.

Dr. Archie Johnson of Raleigh has been chosen as the new Chairman of the MEDPAC Board of Directors, along with Dr. Dave Nelson as Vice Chairman and Dr. John T. Dees as Secretary-Treasurer.

I know these men will guide MEDPAC to new achievements in this coming year.

SPEAKER CARR: Dr. Hollister, we in turn thank you for bringing us up-to-date on the fine work that MEDPAC is doing.

REPORT OF THE SPEAKER

Members of the House of Delegates: This year, it falls my privilege to address you briefly as your Speaker. For a number of years now, I have been honored—actually under my sixth President—to be Vice Speaker and as such have learned much and have benefited greatly from my service under your President-elect Jim Davis.

Last year, it was found advantageous to prepare a report outlining the disposition of all actions taken by this House of Delegates this past year. This report has been prepared and I'm thankful to Mr. Hilliard and his staff for this preparation.

The report you will find in your packet in your desk which are the pink sheets you have among the many papers which you have on your desk.

There is much that goes on in this House that is finalized and has been reported to you in summary form in the blue booklet labeled, "Transactions."

Through this maze of dictation, which is in the main a chronological account in summary form of the transactions of the Society, it is sometimes difficult to quickly determine a specific action. For this reason, the Speaker's report is prepared and has been placed on your desk. It will enable you to trace the business carried out and direct the thoughts of your local societies, not only as to the fate of their own resolutions, but to those others in which they are all interested and I hope that each member of this Medical Society of North Carolina, numbering now over 4400 as you heard, will be interested in all the actions of this House of Delegates.

The House of Delegates is your policy-making body. Let no one of you dispute that fact.

During an interim period between annual sessions, because it has been found so far to be impractical to call more interim plenary sessions of the House of Delegates, the Council acts as your agency, but it is the House of Delegates and your actions concern a great deal of the actions of the Council. I have found that your actions that you've taken here, are the things that determine most often the actions of the Council and you certainly have the privilege at your annual session of reversing or changing the actions of your Council and that is what we are here for at this session.

There are a few things that I might say and that is the plan of procedure for those of you who are new members of the House of Delegates.

The agenda is before you this afternoon and we shall have the introduction of reports and resolutions.

We shall not read in detail the contents and details of these resolutions. The assignments have been made to the Reference Committees under the chairmanship of the two excellent members of the Council. They have been councilors for several years and with the widely distributed membership of the House of Delegates, these matters will be debated and discussed in the Reference Committees at the times and places designated on Friday.

On Saturday, these reports will be brought back for full discussion before the House and the Reference

Committees may wish to modify, or make suggestions for modifications, change some, reject, suggest rejection and suggest acceptance, so it's actually on Saturday and I hope all of you will return for final action determining the action of the House of Delegates which will be had on resolutions and reports before you.

There is a mechanism available to us for late resolutions. It requires a two-thirds acceptance, two-thirds majority of this House to accept late resolutions which were not presented in writing prior to the 13th of April when we had our last Council meeting. This is part of the bylaws and will be adhered to.

If there are late resolutions to be introduced they can be sent to you from the Council or they can be accepted by you and referred to Reference Committees this afternoon on a two-thirds majority vote of all of you here.

Interim disposition of the actions of the 1974 House of Delegates:

1. REPORT A — Annual Budget Estimates for 1974. Operated within the Annual Budget, as approved, see Auditor's Report of 1973 operations contained in the Compilation of Annual Report in Delegate Kits.

2. REPORT B — Report of the ad hoc Committee to Study and Recommend a Salary or Increase in Allowances for the President.

Implemented as approved by payment of a \$25 per diem to the President plus continuing to pay reimbursable expenses including travel, housing, and food, communications, and out-of-pocket expenses while on Society business. Also implemented to reimburse President-Elect and Past President for their travel and living expenses when by virtue of their office they are involved in official Medical Society functions.

3. REPORT C — Request that the Section on Ophthalmology and Otolaryngology be divided into a Section on Ophthalmology and a Section on Otolaryngology.

Implemented by establishment of the two separate Sections approved.

4. REPORT D — Guidelines for a Medical Director in a Long-Term Care Facility. Filed as Society policy.

5. REPORT E — Treatment of Tuberculosis Cases and Potential Cases. Filed as Society policy.

6. REPORT F — Recommendation that Hemophilus Influenza Meningitis be made a Reportable Disease.

Referred to the Committee on Legislation and the State Division of Health Services. Filed as Society policy. (Is now a reportable disease effective 1-1-74 as approved by the Commission for Health Services on 11-29-73.)

7. REPORT G — Change in Dates of Annual Meeting and Survey of the Membership Regarding Choice of May or September.

Implemented, by change to an early May date in keeping with the overwhelming majority vote in the survey of the membership favoring an early or mid-May time of year.

8. REPORT H — Compulsory Continuing Education as a Requirement of Membership.

Referred to the Committee on Medical Education with REPORT O in the Delegates Kit submitted as recommendations of the Committee for the implementation of the action of the House of Delegates.

9. REPORT I — Resolution Regarding the Delivery of Primary Medical Care for Winston-Salem, N. C. (Resolution 12 — 1973 Annual Meeting).

Filed as information. (Original intent of Resolution 12—1973 accomplished)

10. REPORT J — Request for the Establishment of a Section on Neurological Surgery.

Filed, but intent of the Report was implemented by establishment of the Section as authorized by the adoption of REPORT P.

11. REPORT K — Proposed Position Paper "Need for More and Better Distributed Primary Care Physicians."

Filed, as Society policy.

(THERE WAS NOT A REPORT L IN 1974)

12. REPORT M — Proposed Change in the Constitution.

Implemented by change in the Constitution and Bylaws.

13. REPORT N — Purchase of Property Adjacent to the Medical Society Parking Area on Bloodworth Street in Raleigh.

Implemented, by purchase of property as authorized.

14. REPORT O — Amendment to the Medical Practice Act.

Referred to Committee on Legislation, appropriate Legislation being drafted.

15. REPORT P — Proposed Changes in the Constitution and Bylaws.

Implemented, by revision of the Constitution and Bylaws as authorized.

16. REPORT Q — Constitution and Bylaws Change Regarding Compulsory Continuing Education as a Requirement for Membership in the Society.

Implemented, by revision of the Constitution and Bylaws as authorized.

17. REPORT R — Proposed Changes in the Constitution and Bylaws.

Implemented, by revision of the Constitution and Bylaws as authorized deleting the Committee on Memorial Services.

18. Resolution 1 — Professional Standards Review Organizations (PSRO)

Resolution 2 — Repeal of PSRO Act

Resolution 3 — Professional Standards Review Organization

Resolution 7 — Dissolution of the North Carolina Medical Peer Review Foundation, Inc.

Resolution 9 — Professional Standards Review Organization

The Reference Committee consolidated these five resolutions and made a substitute resolution, which was adopted by the House of Delegates. The Substitute resolution filed as Society policy.

19. Resolution 4 — Requirement of Joint Commission on Accreditation of Hospitals for Detailed Delineation of Hospital Staff Privileges

Resolution 4-A — Delineation of Hospital Privileges by Specific Procedure

Resolution 8 — Resolution on Delineation of Privileges

The Reference Committee consolidated these three resolutions and presented a Substitute Resolution, which was adopted by the House of Delegates. Resolution submitted to the AMA House of Delegates in keeping with the instructions of the North Carolina Medical Society May 1974 House of Delegates, becoming Resolution 103 (A-74). The AMA House of Delegates amended the Resolution in Reference Committee, but

the basic intent of the North Carolina Resolution was adopted.

20. Resolution 10 — Chiropractors on the Board of the North Carolina Division of Health Services

Amended and adopted, with a letter being transmitted to the Governor of North Carolina expressing the North Carolina Medical Society concern.

21. Resolution 11 — Opposition to Chiropractic School Accreditation and Repeal of Legislation Recognizing Chiropractors as being Eligible for Medicare and Medicaid Funds

Amended and adopted, with a letter being transmitted to the Dean of Gardner-Webb College expressing the North Carolina Medical Society disapproval of practice of granting educational credit for transfer of credit from a Chiropractic school. Also referred to the Committee on Legislation.

22. Resolution 12 — Ending Cost of Living Council Controls and Expiration of the Present Economic Stabilization Act

Filed, by May 1974 House of Delegates, as resolution no longer timely.

23. Resolution 13 — Membership of the Council on Medical Education of the AMA

Amended and adopted. Resolution submitted to the AMA House of Delegates in keeping with the instructions of the May 1974 House of Delegates, becoming Resolution 104 (A-74). The AMA House of Delegates considered this resolution along with two others on related subjects. The AMA House of Delegates adopted a substitute resolution suggesting that a close review of the status of the members of the Council be made before nomination and electing new members to the Council, but that adoption of the resolutions as presented would limit the options available to the House relative to the composition of the Membership of the Council.

24. Resolution 14 — Encouraging Membership in N. C. MEDPAC

Amended and adopted. Filed as Society policy.

25. Resolution 15 — Medical Specialty Examining Boards

Adopted and Resolution submitted to the AMA House of Delegates in keeping with the instructions of the May 1974 House of Delegates, becoming Resolution 105 (A-74). The Resolution was subsequently referred to the AMA Board of Trustees with Report G of the AMA Board of Trustees dealing with the subject of the original resolution being adopted in lieu of the North Carolina resolution.

That in essence, is my message.

Reference Committees, incidentally, are open to any member of the membership of the North Carolina Medical Society or any non-member, outsiders, who care to speak and are recognized and are accepted by the Chairman of the Reference Committee as being resource people or people who have knowledge that may be of help to the Reference Committee and the House of Delegates when they make their report.

NOMINATION AND ELECTION OF OFFICERS

The next item is the report of the Nominating Committee and this, I would remind you, will be in two parts.

One is the slate of officers which is in a sealed envelope in the possession of the current President. When he reads the slate of officers, these are nominations.

The second part of the nominating procedure is a report from Dr. Dixon on the nominations previously sent to you in open form which places this slate of nominees in nomination. I call on Dr. Reynolds to present the nominations for the slate of officers as he has received it from the Nominating Committee.

PRESIDENT REYNOLDS: Thank you, Mr. Speaker.

As most of you are aware, it is customary for the Chairman of the Nominating Committee, this year Dr. Elliott Dixon from Ayden, to mail to the President the slate of nominations. This is kept in secrecy and opened at this time. The report of the Committee on Nominations 1975:

President-elect, one year, Dr. Jesse Caldwell;

First Vice President, one year term, Dr. John McCain;

Second Vice President, one year term, Dr. Thomas Reginald Harris;

Secretary, no vacancy;

Speaker of the House of Delegates, one year term, Dr. Chalmers Carr;

Vice Speaker of the House of Delegates, one year term, Dr. Henry Carr;

Mr. Speaker, I present this to the House for their action.

SPEAKER CARR: The floor is now open for nominations. This is for any office, I'll go down the list:

President-elect; First Vice President; Second Vice President; Speaker; Vice Speaker. Are there any nominations?

DR. LOUIS deS. SHAFFNER: I move nominations be closed.

[The motion was duly seconded from the floor.]

SPEAKER CARR: It has been moved and seconded that the nominations be closed.

DR. ALEXANDER MAITLAND [Buncombe County]: I move they be elected by acclamation.

DR. GEORGE G. GILBERT [Buncombe County]: Second.

SPEAKER CARR: All in favor say "aye." Opposed "No." They are elected.

DR. J. ELLIOTT DIXON [Chairman, Nominating Committee]: Mr. Speaker, Members of the House of Delegates: Following is the remainder of the report of the Committee on Nominations:

Councilors for three year terms:

Fifth District, August Oelrich;

Vice Councilor, Bruce Blackmon;

As the Fifth District submitted its own nominations, we are required by the Constitution to poll the delegates from that District. This was done. Of the eleven delegates they were all contacted, eight responded and did approve these nominations. Three did not respond.

From the Seventh District, for Councilor, Dr. William T. Raby; Vice Councilor, Dr. J. Dewey Dorsett;

From the Tenth District, Dr. Kenneth E. Cosgrove; Vice Councilor, Dr. Otis B. Michael;

North Carolina Board of Medical Examiners: no vacancies.

For AMA Delegates, January 1, 1976 to December 31, 1977:

Dr. David G. Welton and Dr. Edgar T. Beddingfield, Jr.

For AMA Alternate Delegates; January 1, 1976 to December 31, 1977:

Dr. D. E. Ward, Jr., and Dr. Charles W. Styron.

North Carolina Commission on Health Services (formerly State Board of Health):

Dr. Paul F. Maness and Dr. William Dennis Rippy. North Carolina Medical Care Commission, four year terms:

Dr. John F. Lynch, Jr.

Editorial Board, NORTH CAROLINA MEDICAL JOURNAL, four year term:

Dr. Robert E. Whalen and Dr. Charles W. Styron.

North Carolina Blue Cross and Blue Shield, Inc., Board of Directors for three year terms:

Dr. H. Fleming Fuller and Dr. Alfred T. Hamilton. Retirement Savings Plan Committee for three year terms:

Dr. William F. Hollister, Dr. Joseph B. Stevens and Dr. Thomas N. Lide.

Committee on Blue Shield for three year terms:

Dr. William F. Crutchley, Jr., (GS) (I)

Dr. David O. Wright (FP) (I)

Dr. James E. Collins (P) (VIII)

Dr. John R. Marchese (OBGY) (IX)

Dr. D. Clark Bright (Anesthesiology) (VI)

Dr. Edwin L. Bryan (IM) (VIII)

Dr. H. Maxwell Morrison, Jr. (OPH) (V)

Dr. Freeman Albert Berne (R) (V)

Dr. Wilbur Thadeus Shearin (U) (III)

This completes the report of the Nominating Committee.

SPEAKER CARR: Thank you, Dr. Dixon.

You've heard the report of the Nominating Committee and you've previously seen it, since this was the portion that was mailed to you.

Do I have a motion that the report be received?

[The motion was duly made and seconded from the floor, for the report to be received, put to a vote and passed.]

The report is received and these names are in nomination.

Are there nominations from the floor for any office named or listed on this report of Dr. Dixon?

DR. SOHMER: Delegate from Forsyth County! Mr. Speaker, it is my pleasure to place in nomination Dr. F. A. "Ted" Blount as a member of the Board of Trustees of North Carolina Blue Cross and Blue Shield.

Dr. Blount for eight to ten years has served in an excellent and faithful manner on this Board and is the only pediatrician on this board.

The six remaining members that are proposed on that Board either now are members or will be elected members, represent internal medicine, surgery and surgical sub-specialties.

It seems appropriate to keep an individual such as Dr. Blount on the Board.

I recognize the very, very difficult decision that the Nominating Committee had. It was referred to by Dr. Reynolds. It is now federal regulation that the Boards of the Blue Cross are made up of a majority of consumers, thereby the Nominating Committee was faced with the very difficult task of choosing from the very capable people who were up for re-election—Dr. Stevens, Dr. Fleming Fuller, Dr. Hamilton and Dr. Blount, and it's unfortunate that we are losing these places as we are and think that we should give very serious consideration to this very important position. Thank you.

SPEAKER CARR: The name of Dr. Blount is now

in nomination along with the two additional nominees from the Nominating Committee.

Are there further nominations from the floor for any positions?

In matters of this kind, I think it is wise that we have a ballot, unless this decision of the chair is overruled.

The tellers have been alerted. The ballots are available. We ask that you vote for two of the three. Dr. Fleming Fuller, Dr. Alfred Hamilton and Dr. Ted Blount.

Vote for two of the three, and no more than two!

(See Page 69, for the announced results of the balloting.)

While the tellers are doing their job, I think it's quite important for you to at least see our President-elect and I'll ask Dr. Charles Styron to escort Dr. Jesse Caldwell to the podium to say hello to us.

[Whereupon Dr. Styron then escorted Dr. Caldwell to the podium, during which time he was accorded a standing ovation.]

DR. JESSE CALDWELL, Jr [Gaston County]: Thank you, ladies and gentlemen. I hardly know what to say.

I was looking forward to perhaps early retirement but I believe I'll devote my duties to the organization as much as I can and I want to thank you again—I think!

SPEAKER CARR: To save your time, "while the Tellers are counting the ballots we will go ahead with the report of the Committee on Constitution and By-laws.

CONSTITUTION AND BYLAWS

DR. SHAFFNER [Chairman, Committee on Constitution and Bylaws]: Mr. Speaker, Members of the House:

If you will take out Report "Q" from your packets we will consider this, Report "Q", Report of the Committee on Constitution and Bylaws.

The Committee on Constitution and Bylaws has reviewed the following proposed changes and submits them for consideration by the House of Delegates.

For clarification, in some instances, deleted words are crossed and added words are underlined.

Item 1. This is identical to the Constitution and Bylaws Report "D", which is also in your packets. The reason it is referred to here is for completeness and both Report "D" and this item will go to the Reference Committee.

REPORT Q

Subject: Proposed Changes in the Constitution & Bylaws Referred To: Reference Committee No. 1

The Committee on Constitution and Bylaws has reviewed the following proposed changes and submits them for consideration by the House of Delegates.

Item 1: (Identical to Constitution and Bylaws Report D)—Change in Constitution Intern Resident Members. This change will assure that intern/resident members, who like active members are licensed to practice medicine in North Carolina will have similar privileges.

Amend Article IV, Section 6 (page 4) by deleting the word "student" in the last sentence and inserting in lieu thereof the word "active." The sentence will then read:

"They shall have the same rights and privileges as active members."

The committee recommends that this change be accepted for consideration, the final vote to be taken by the House in 1976.

Item 2: Bylaw Change, Committee on Arrangements

The Council on Review and Development recommended and the Executive Council approved a proposal to combine the Committee on Arrangements and the Committee on Programs for the General Sessions so that there could be easier coordination in planning the annual meeting. The Committee on Programs is not now provided for in the Bylaws. The following change will add the duties of that committee to that of the Committee on Arrangements.

Amend Bylaw Chapter X, Section 6 (page 37) by adding the underlined words so that the section will read:

"Section 6. The Committee on Arrangements shall consist of three *or more* members. It shall arrange suitable accommodations as the meeting places of the Society, the House of Delegates, and respective committees and *sections*, and shall have general charge of *planning programs for the general sessions and* of all arrangements of facilities for the holding of the annual meeting . . . etc."

Item 3: Committee on Blue Shield (Same as Report H of the Executive Council)

Report H of the Executive Council approves a recommendation that the Committee on Blue Shield be appointed by the President rather than elected by House of Delegates. The wording of the proposal in Report H has been changed to better conform with the format of other committee bylaws.

Amend Bylaw Chapter X, Section 14 (page 49) by deleting the first six sentences and substituting therefore the following:

"A Committee on Blue Shield consisting of at least one member representing each major practice specialty shall be appointed by the President for one year terms subject to reappointment, except that no member may serve more than five terms in any eight year period. The President shall seek recommendations for membership from the specialty sections and shall endeavor to ensure as full a geographic and specialty representation as practical for proper functioning of the Committee."

Item 4: Committee on Medical Education

The Committee on Medical Education has recommended that membership on the Committee not be limited to one five year term. To retain this limit could exclude from membership the one man in each of the State's medical schools who is responsible for continuing education and who would be valuable as a continuing committee member.

The Committee on Constitution and Bylaws questions the advisability of continuing the appointment of members to a five year term. Rather, the President would have more flexibility in appointing the membership if appointments are for one year terms subject to reappointment. The Committee therefore recommends the following:

Amend Bylaw Chapter X, Section 19 (page 53) by changing one sentence to read as follows and deleting two sentences.

"Appointments shall be made for a term of *one* year, subject to *reappointment*."

Item 5: Transfer Jones County to Craven-Pamlico (Same as Report J of the Executive Council)

Report J of the Executive Council speaks to the

recommendation that Jones County be removed from Lenoir-Greene-Jones County Medical Society and joined with Craven-Pamlico County Medical Society to become Craven-Pamlico-Jones County Medical Society.

Bylaw Chapter IV, Section 10 (page 18) authorizes the formation of hyphenated societies by the House of Delegates, and thereby implies that the House may sanction the withdrawal of Jones County from one County Society and the joining with another.

The Committee on Constitution and Bylaws sees no need for a Bylaw change and recommends that the House approve the joining of Jones County to form the Craven-Pamlico-Jones County Medical Society.

SPEAKER CARR: You have heard the report of the Chairman of the Committee on Constitution and Bylaws. This will be referred to Reference Committee I.

We will now have the report of the tellers on the Blue Cross and Blue Shield Board of Directors.

DR. L. H. ROBERTSON: Mr. Chairman, do you want the numbers or just the names at the top?

SPEAKER CARR: Tell us who is elected, please.

DR. ROBERTSON: Drs. Fuller and Blount.

SPEAKER CARR: Dr. Fuller and Dr. Blount have been elected by the House.

Is there a question of polling the House?

[No response]

If not, I declare these elected.

(At the Second meeting of the House of Delegates on Saturday, May 3, 1975 the Speaker called attention to the fact that the Constitution and Bylaws, and parliamentary procedure require that in an election for members of the Board of Directors of Blue Cross and Blue Shield that members be elected by a majority vote. He advised the House that since no announcement had been made during the earlier vote as to the total number voting nor of the number of votes for each candidate that proper procedure had not been followed nor had a majority vote been declared by the chair.

The Speaker announced that he felt that a request for a re-ballot would be in order.

A re-ballot followed with the announced results of 114 votes for Dr. Fuller; 100 votes for Dr. Blount, and 97 votes for Dr. Hamilton. A motion was passed to elect the top two whereupon the Speaker declared Dr. Fuller and Dr. Blount elected)

All right, we'll now go on to the next order of business.

ANNUAL REPORTS

The next order of business is consideration of the Annual Reports. The Annual Reports are contained in the white booklet in your packets, entitled, "Compilation of Annual Reports."

The Chair will ask at this time if there are any Councilors, chairmen of committees, commissioners, or others who are included in the Compilation of Annual Reports, who wish to make any additions or changes in their reports. It's appropriate that they do so at this time.

[A motion was duly moved, seconded from the floor and passed on voice vote that the compilation of Annual Reports be accepted as printed.]

The compilation of Annual Reports is accepted as printed.

I'm going to break in at this one moment, by unanimous consent, to recognize and ask Mrs. Ruth Patterson of Concord to stand for a very brief moment

for recognition. She is President of the American Association of Medical Assistants, North Carolina State Society. She happens to work for Dr. Fred Craven of Concord.

We are all proud, Mrs. Patterson, of our medical assistants. Thank you.

MRS. RUTH PATTERSON: We appreciate it. Thank you.

SPEAKER CARR: Next, we have a report from the Executive Council by Dr. Frank Reynolds, our President.

EXECUTIVE COUNCIL SUMMARIES AND REPORTS OF THE EXECUTIVE COUNCIL

PRESIDENT REYNOLDS: Thank you, Mr. Speaker.

Each of you received in your delegates' packets a Summary of the Actions of the Executive Council at each of their three sessions which were on September 29th of last year, February 2nd this year and April 13th.

These three summaries represent actions by the Executive Council which it felt did not require special reports but which are submitted in summary form for your consideration and, hopefully, for your approval.

You also have in your delegates' packets Reports "A" through "S" which originated from actions of the Executive Council at these three meetings.

The Chairman of the Committee on Constitution and Bylaws, Dr. Shaffner, just presented to you the

recommendations contained in Reports "D", "H", "J" and "Q."

I therefore move that these summaries be approved and the lettered reports as printed with the exception of those already presented by the Committee on Constitution and Bylaws be received at this time for consideration by the House of Delegates and referral to the Reference Committees as indicated without being read at this session.

[The motion was duly seconded from the floor.]

SPEAKER CARR: It has been moved and seconded that the Executive Council Summaries be approved and that these reports be received and referred to Reference Committees as indicated.

Any discussion of this motion?

All in favor say "aye"; opposed "no."

The motion is carried, and the reports of the Executive Council are referred.

REPORT A

SUBJECT: Annual Budget Estimates for 1975

REFERRED TO: Reference Committee No. 1

The September 29, 1974, meeting of the Executive Council considered the proposed budget for 1975 as recommended by the Committee on Finance.

On a motion duly seconded, the budget estimates for 1975 were approved and adopted by the Council.

The Budget Estimates for 1975 are as follows:

BUDGET ESTIMATES January 1, 1975 to December 31, 1975

	1974	1975
REVENUES: (ESTIMATED)		
Estimated balance January 1, 1975.....	NIL	\$ 60,000
Annual Dues, paying members.....	\$376,000	445,000
Sales—Rosters & Journals.....	5,600	5,600
Revenue Unexpected.....	4,500	5,000
Technical Exhibits.....	10,560	10,500
Journal Advertisement—Local.....	10,000	9,500
Journal Advertisement—National.....	35,000	25,000
**AMA Remittance 1% of dues processed—plus interest.....	7,500	10,000
MEDPAC Remittance 1% of dues processed.....	220	250
Rental Income—New Headquarters Facility.....	50,936	53,691
Rental Income—Residential Property (new account).....	—0—	1,800
Interest Income—Operating Funds.....	6,000	9,000
Interest Income—Notes Receivable—Sale of Property (new account).....	—0—	12,679
Interest Income on Reserve Fund (new account).....	—0—	8,500
	<u>\$506,316</u>	<u>\$656,520</u>
EXPENDITURES: (ESTIMATED)		
Schedule A.....	\$228,910	\$264,215
Schedule B.....	86,425	89,625
Schedule C.....	34,790	35,225
Schedule D.....	18,100	18,525
Schedule E.....	8,610	9,560
Schedule F.....	21,490	25,650
Schedule G.....	52,541	52,497
Schedule M.....	55,450	60,300
Schedule R (new account).....	—0—	100,923
	<u>\$506,316</u>	<u>\$656,520</u>

** To be appropriated to Secretarial Budget A-6.

	1974	1975
EXCESS OF RECEIPTS OVER EXPENDITURES.....	—0—	—0—
EXCESS OF EXPENDITURES OVER RECEIPTS.....	—0—	—0—
RESERVES: (estimated Cash Reserves—\$131,390).....		
SUBMITTED TO COMMITTEE ON FINANCE.....	September 15, 1974	
SUBMITTED TO EXECUTIVE COUNCIL FOR APPROVAL.....	September 29, 1974	
SUBMITTED TO HOUSE OF DELEGATES FOR APPROVAL.....	May 1, 1975	

A. EXECUTIVE BUDGET

A-1 President, expense of (travel & communications)*.....	\$ 8,000	\$ 8,000
A- 2 President's secretarial assistance.....	4,000	4,000
A- 3 Secretary, travel of*.....	1,000	1,000
A- 4 Executive Director-Treasurer, salary of.....	26,160	31,000
A- 5 Executive Director-Treasurer, travel of*.....	6,500	6,500
A- 6 Executive Office, Secretarial & Clerical Assts.*.....	53,000	61,000
A- 7 Executive Office, equipment-replacements.....	4,000	4,000
(a) Reserve for future equipment replacements.....	—0—	2,000
A- 8 Executive Office, expense of (communications, printing, and supplies, repairs & replacements of expendables).....	20,000	21,600
A- 9 Bonding (in effect to 1975).....	—0—	1,200
A-10 Audit (Quarterly & Annual).....	2,300	2,400
A-11 Taxes (salary tax).....	7,600	9,100
A-12 Insurance: fire, liability & compensation.....	2,200	2,200
A-13 Membership Record, Acctg., IBM Machine Rental, Forms.....	10,400	10,700
A-14 Publications, reports & executive aids.....	300	350
A-15 Assistant Executive Director, salary of (Employee resigned March 1974).....	18,700	—0—
A-16 Assistant Executive Director, travel of (Employee resigned March 1974).....	3,500	—0—
A-17 Assistant to Executive Director & Convention Coordinator, salary of.....	14,550	17,250
A-18 Field Representative, salary of (MC).....	Employed July 1974	10,200
A-19 Field Representative, salary of (JE).....	Employed Aug. 1974	11,000
A-20 Director, Field Services, travel of (New line item for 1975—see item A-25 for 1974).....	See A-25	3,000
A-21 Director, Governmental Affairs, travel of (New line item for 1975—see item A-25 for 1974).....	See A-25	2,000
A-22 Controller, salary of.....	16,600	19,090
A-23 Director, Field Service, salary of (GS) (Title changed from Field Representative —effective May 1974).....	13,500	16,675
A-24 Director, Governmental Affairs, salary of (Title changed from Field Representative —effective May 1974).....	10,600	14,950
A-25 Field Representatives, travel of.....	6,000	5,000
(1974—Represents items A-23 & A-24)		
(1975—Represents items A-18 & A-19)		
	<u>\$228,910</u>	<u>\$264,215</u>

B. JOURNAL BUDGET

B- 1 Journal, printing and mailing.....	\$ 62,000	\$ 63,000
B- 5 Editorial Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements).....	850	850
B- 6 Journal Business Manager's Office, expense of (12 months communications, printing, and supplies, repairs and replacements).....	925	925
B- 7 Business Manager's Office, equipment for.....	100	100
B- 8 Journal, travel for (Local & National).....	100	100
B- 9 Taxes (Salary tax).....	1,200	1,250
B-10 Sales tax on Journal Subscriptions and Roster Sales.....	2,500	2,400
B-11 Journal Salaries (Editor, Assistant Editor, Advertising Secretary).....	18,850	21,000
	<u>\$ 86,425</u>	<u>\$ 89,625</u>

C. INTRA-FUNCTIONAL ACTIVITY BUDGET

C- 1 Executive Council expense of and travel of Councilors including district travel.....	\$ 4,500	\$ 4,500
C- 2 Publication of Executive Council Minutes, Transactions, Annual Reports.....	5,500	5,800

* Basis: Real for personal maintenance and travel @17¢ per mile and/or common carrier rate and for official purposes.

** Any revenue derived from collection efforts related to American Medical Association dues and processing of same shall accrue to this item of the Budget.

	1974	1975
C- 3 Legislative Committee, expense of (Local and National activity).....	6,500	6,500
C- 4 Maternal Health Committee, expense of (secretarial communications, printing and supplies)	300	300
C- 5 Committee on Drug Abuse	200	200
C- 6 Committee on Arrangements	C-11	C-11
C- 7 Committee on Exhibits, expense of (including \$200 for Scientific Exhibit Awards and \$200 for Student Scientific Exhibit Award).....	1,220	1,250
C- 8 Committee on Mental Health	400	400
C- 9 Committee on Mediation	500	1,000
C-10 Committee on Chronic Illness, TB & Heart Disease.....	C-11	C-11
C-11 Committees in general, expense of (including committees under \$100 allocations)	4,500	4,500
C-12 Committee on Nominations	C-11	C-11
C-13 Committee on Occupational & Environmental Health.....	200	200
C-14 Committee on Professional Insurance	C-11	C-11
C-15 Committee on Relative Value Studies.....	600	400
C-17 Committee Advisory to Medical Students (Section) (Expense of Delegate to SAMA and AMA Annual Meeting—one each Medical School Chapter (3)).....	2,000	1,725
C-18 Committee on Disaster & Emergency Medical Care.....	600	600
C-19 Committee on Industrial Commission	C-11	C-11
C-20 Committee on Constitution and Bylaws.....	500	500
C-21 Committee on Medical-Legal	C-11	C-11
C-22 Committee on Traffic Safety (Formerly—Advisory to N. C. Department of Motor Vehicles)	C-11	C-11
C-23 Committee on Cancer	C-11	C-11
C-24 Committee on Anesthesia Study	320	350
C-25 Committee on Child Health & Infectious Disease.....	C-11	C-11
C-26 Committee on Blue Shield	C-11	C-11
C-27 Committee on Hospital & Professional Relations & Liaison to N. C. Hospital Association	C-11	C-11
C-28 Committee on Social Services Program.....	C-11	C-11
C-29 Committee on Memorial Services (Necrology).....	C-11	dissolved
C-30 Insurance Industry Committee.....	800	200
C-31 Committee on Community Medical Care, sponsorship of 4-H Health activity for one trip to National 4-H Club for State Health Winner, and Today's Health subscription to 4-H Health winners; Dues Rural Health Safety Council; Miscellaneous expense	500	500
C-32 Committee on Retirement Savings Plan.....	C-11	C-11
C-34 Committee on Programs for General Sessions.....	1,500	C-11
C-36 Committee on Marriage Counseling & Family Life Education.....	500	500
C-37 Committee on Medicine and Religion.....	350	500
C-38 Committee Advisory to Auxiliary (Chairmanship includes Auxiliary under item D-3)	C-11	C-11
C-39 Committee on Credentials	C-11	C-11
C-40 Committee on Scientific Awards	C-11	C-11
C-41 Committee on Physical & Vocational Rehabilitation.....	C-11	C-11
C-42 Committee on Eye Care and Eye Bank.....	C-11	C-11
C-45 Council on Review and Development.....	C-11	C-11
C-46 Committee on Finance	C-11	C-11
C-48 Committee on Medicare	C-11	C-11
C-49 Committee on Medical Education	1,000	4,000
C-50 Committee on Comprehensive Health Service Planning.....	C-11	C-11
C-51 Committee on Medical Aspects of Sports.....	1,000	1,000
C-52 Committee on Association of Professions.....	C-11	C-11
C-53 Committee on Allied Health Professionals (Formerly—Physicians on Nursing).....	200	C-11
C-54 Committee Liaison to N. C. Pharmaceutical Association.....	C-11	C-11
C-55 Committee on Personnel & Headquarters Operations.....	C-11	C-11
C-57 Committee on Advisory to Crippled Children's Program.....	C-11	C-11
C-58 Committee on Peer Review	200	C-11
C-59 Committee on Health Care Delivery.....	750	dissolved
C-60 Committee on Archives of History—NCMS.....	C-11	dissolved
C-61 Committee on Audio-Visual Programs	150	300
	<u>\$ 34,790</u>	<u>\$ 35,225</u>

1974

1975

D. EXTRA-FUNCTIONAL ACTIVITY BUDGET

D- 1 Delegates to AMA, expense of (8 including alternates to each Annual and Clinical Session)	\$ 11,100	\$ 11,500
D- 2 Conference Dues	250	250
D- 3 Woman's Auxiliary (contribution to entertainment, travel to National Auxiliary for 2 and productions)	5,400	5,400
D- 5 President's Communication Program (Newsletter)	1,350	1,375
	<u>\$ 18,100</u>	<u>\$ 18,525</u>

E. PUBLIC RELATIONS BUDGET

E- 3 Committee Chairman, out-of-state travel	\$ 500	\$ 500
E- 9 Audio-Visual depiction, photography, radio-motion pictures, production, distribution and printing, purchase of films, etc.	100	100
E-10 Educational distribution; reprints, periodicals press materials, pamphlets, and dodgers for educational purposes, production, and distribution and printing, binding, stuffing and mailing	300	300
E-11 News and press releases, production and printing of	200	200
E-12 Public Relations Bulletin, production and printing of	3,800	4,300
E-13 State High School Science Fair Program, Award for	160	160
E-14 Exhibits and Displays: purchase, rental, production, fabrication and transportation of	500	500
E-15 Conference for Medical Leadership	1,500	1,500
E-17 Today's Health Magazine subscriptions	850	1,300
E-18 Collateral Public Relations with other Committees	500	500
E-19 N. C. Rescue Squad First Aid Trophies	200	200
	<u>\$ 8,610</u>	<u>\$ 9,560</u>

F. ANNUAL SESSIONS (121st) CONVENTION BUDGET

F- 1 Program, Production of	\$ 2,000	\$ 2,500
F- 2 Hotel and Auditorium expense	5,000	6,000
F- 3 Publicity promotion, expense of (reporters and expense)	600	600
F- 4 Entertainment (general involving personnel)	1,200	1,200
F- 5 Orchestra and Floor entertainment	2,500	2,500
F- 6 Guest Speakers expense and/or honorarium	500	2,500
F- 8 Electric Amplification, operators, installations and screening auditorium	—0—	—0—
F- 9 Booth installations, supplies, expense signs (Scientific and Technical) including exhibit expense & promotion	4,500	5,000
F-10 Projection, expense of (service rentals)	800	800
F-11 Badges (members, guests, exhibitors, auxiliary)	250	250
F-12 Reporting Service for Transactions—(House of Delegates, General Sessions and Reference Committees)	2,500	2,500
F-13 Rental, extra facilities, trucks for sections and/or exhibits	200	200
F-14 Exhibitors entertainment	850	1,000
F-15 Banquet expense	200	200
F-16 Police Security	390	400
	<u>\$ 21,490</u>	<u>\$ 25,650</u>

G. MISCELLANEOUS BUDGET

G- 1 Legal Counsel, retainer fees for	\$ 16,800	\$ 20,000
G- 2 Reporting, Executive Council Meetings	2,000	2,000
G- 3 Fifty Year Club Pins and Certificates and President's Jewel	350	400
G- 4 Contingency and Emergency	3,229	1,215
G- 5 Retirement System for Society	21,000	17,700
G- 6 Advalorem Taxes (Personal Property)	900	950
G- 7 Association of Professions	200	200
G-10 Commissioners, expense of	1,500	1,500
G-11 Executive Committee, expense of	300	300
G-12 Officers, expense of	2,000	2,000
G-13 Travel and Maintenance, expense of essential headquarters staff for out-of-state meetings and in-state conferences	2,000	2,500

	1974	1975
G-14 NCMS Headquarters Staff Hospitalization.....	2,262	2,980
G-15 Other Property Taxes and Insurance (Fonville Property).....	—0—	252
G-16 Residential Property Repairs (Fonville Property).....	—0—	500
	<u>\$ 52,541</u>	<u>\$ 52,497</u>

M. HEADQUARTERS FACILITY BUDGET*Operating Costs:*

M- 5 Utilities	\$ 15,000	\$ 18,000
M- 6 Insurance	1,750	1,750
M- 7 Taxes (Real Property).....	16,200	17,000
M- 8 Water	500	550
M- 9 Janitorial Services	13,500	14,000
M-10 Grounds Maintenance	1,500	1,500
M-11 Building Repairs & Maintenance.....	4,000	4,000
M-12 Heating A C Repairs & Maintenance, Elevator Maintenance.....	3,000	3,500
	<u>\$ 55,450</u>	<u>\$ 60,300</u>

R. OPERATING BUDGET RESERVES

R- 1 Interest on Notes Receivable—sale of property.....	—0—	\$ 12,679
R- 2 Interest on Reserve Fund.....	—0—	8,500
R- 3 Extra Dues for Reserve Fund.....	—0—	52,000
R- 4 5% of Operating Budget.....	—0—	27,744
	<u>—0—</u>	<u>\$100,923</u>

REPORT B

Subject: State Emergency Medical Services Program
 Referred to: Reference Committee No. II

The September 29, 1974, meeting of the Executive Council received and approved a report from the Committee on Disaster and Emergency Medical Care summarizing the State Emergency Medical Services program established in the Department of Human Resources, and requested support of the Society in its implementation as follows:

The North Carolina Medical Society supports the concept of the development of emergency medical services in the State of North Carolina and training of ambulance attendants and ambulance drivers with the development of minimal statewide training criteria and evaluation with certification; (b) the development of minimal standards for ambulance vehicles; (c) the development of an integrated statewide communication program; (d) a categorization of hospitals to assist in identifying area resources and ultimately to assist in coordinating emergency medical care delivery; (e) the development of specialized training programs for such personnel as mobile intensive care technicians and emergency department technicians (f) the development of a statewide air transportation system.

The North Carolina Medical Society recommends continuing legislative support of the present statewide program of emergency medical care now being implemented by the Office of Emergency Medical Services.

REPORT C

Subject: One-hundred Percent Reimbursement of Usual, Customary, and Reasonable Fees in the Medicaid Program

Referred to: Reference Committee No. II

The September 29, 1974, meeting of the Executive Council voted approval of a recommendation from the ad hoc Study Committee on Fees urging that the Society strongly support one-hundred percent reimbursement of usual, customary and reasonable fees in the Medicaid program.

(As information, the Medicaid program in the State of North Carolina currently pays ninety percent of what is determined to be usual, customary and reasonable up to the seventy-fifth percentile.)

REPORT D

Subject: Proposed Change in the Constitution

Referred to: Reference Committee No. I

(Identical to Item I, Report Q, Report of the Committee on Constitution and Bylaws. See Page 75.)

REPORT E

Subject: Prophylactic Treatment of Tuberculosis in North Carolina

Referred to: Reference Committee No. II

The September 29, 1974, meeting of the Executive Council considered and approved a recommendation from the Committee on Chronic Illness approving the use of prophylactic treatment of tuberculosis in North Carolina so as to conform with the standards of the

Center for Disease Control of the U. S. Public Health Service.

Current Trends

PREVENTIVE THERAPY OF TUBERCULOUS INFECTION

The following recommendation on the use of isoniazid for preventive treatment of tuberculosis is a joint statement from the American Thoracic Society, American Lung Association, and the Center for Disease Control. It supersedes previous statements and recommendations on preventive therapy, including "Isoniazid-Associated Hepatitis: Summary of the Report of the Tuberculosis Advisory Committee and Special Consultants to the Director, Center for Disease Control" which appeared in Volume 23, No. 11, of the *Morbidity and Mortality Weekly Report*, March 1974. The current recommendation was previously published in the *American Review of Respiratory Disease*, Volume 110, No. 3, September 1974.

Antimicrobial drugs, which have revolutionized the therapy of tuberculosis, can also be used to prevent disease in the infected individual. Preventive therapy (chemoprophylaxis) presumably acts by diminishing the bacterial population in "healed" or roentgenographically invisible lesions of the person taking the drug. It is, in reality, treatment of infection and can prevent progressive tuberculosis from developing.

A substantial and growing body of scientific data testifies to the value of isoniazid (INH) in prevention of the disease tuberculosis. The extensive trials conducted by the U. S. Public Health Service show a consistent reduction of morbidity in treated groups; it seems reasonable to expect that preventive therapy can substantially reduce future morbidity from tuberculosis in high risk groups.

Drugs used in Preventive Therapy

A single drug, INH, is used for preventive therapy in a dose of 300 mg per day for adults and 10 mg per kg body weight per day, not to exceed 300 mg per day, for children, to be administered in a daily single dose over a period of 12 months. A larger dose or longer period of time is not required. INH is inexpensive, administered orally, and easy to take. As of now, no other drug has been demonstrated to be effective for preventive therapy.

It is now apparent that mild hepatic dysfunction evidenced by elevation of serum aminotransferase (transaminase) activity, occurs in 10 to 20 percent of persons taking INH. This abnormality usually occurs in the first 4 to 6 months of treatment but can occur at any time during therapy. In most instances, enzyme levels return to normal with no necessity to discontinue medication. In occasional instances, progressive liver damage occurs and presents symptoms; the drug should be discontinued immediately in these cases. The frequency of progressive liver damage increases with age. It is rare in individuals under age 20. The observed frequency in other age groups is as follows: ages 20-34,

up to 0.3 per cent; ages 35-49, up to 1.2 per cent; 50 years and more, up to 2.3 per cent.

It must be remembered that the chance of developing INH-associated liver disease exists only during the year of preventive therapy, whereas the risk of developing tuberculous disease is present for life. It is to diminish the risk of developing tuberculosis, with possible transmission of infection, that INH is recommended for persons infected with *M. tuberculosis*. U. S. Public Health Service studies have demonstrated that the protection of one year of preventive therapy for those at risk of developing tuberculous disease continues for many years and may well be lifelong. Up to 15 years of follow-up of groups of people given preventive therapy with INH has revealed no evidence of delayed deleterious effect. The recommendations outlined below for the use of INH with appropriate safeguards are based on a comparison of the risk of hepatic injury with the benefit of preventive therapy.

Persons for Whom Preventive Therapy is Recommended

Every positive tuberculin skin test reactor is at some risk of developing tuberculous disease and can benefit from preventive therapy. Since the risk of developing disease is lifelong, the benefit from preventive therapy is greater the younger the age and the longer the life expectancy. Hepatitis, the most serious complication of INH therapy, increases with age. The risk of hepatitis is exceedingly low in the less than age 20 group and reaches a peak among persons more than 50 years of age.

Priorities must be set for preventive therapy, taking into consideration not only the risk of developing tuberculosis compared with the risk of INH toxicity, but also the ease of identifying and supervising persons for whom preventive therapy is indicated, and their likelihood of infecting others.

The following groups are listed in order of priority:

1. Household members and other close associates of persons with recently diagnosed tuberculous disease.
2. Positive tuberculin skin test reactors with findings on the chest roentgenogram consistent with nonprogressive tuberculous disease, in whom there are neither positive bacteriologic findings nor a history of adequate chemotherapy.
3. Newly infected persons.
4. Positive tuberculin skin test reactors in the special clinical situations described below.
5. Other positive tuberculin skin test reactors. The risk of tuberculosis is highest in infancy, high again in adolescence and early adult life, and continues at a lower rate for a lifetime.

1. Household Members and Other Close Associates. Household members and other close associates of patients with newly discovered tuberculous disease are at high risk of being recently infected and of developing disease. The risk is approximately 2.5 per cent for the first year. However, the risk is approximately 5.0 per cent for those already infected (tuberculin positive) at the time of the initial examination. Contacts of patients should be examined and those diagnosed as having tuberculous disease should be treated with multiple drug therapy. All other contacts with Mantoux tuberculin skin test readings of 5 mm or more should receive preventive therapy, since in this group such reactions are likely to be due to infection with *M. tuberculosis*.

* For definition of infection with *M. tuberculosis* and techniques for administering and reading skin tests, see "The Tuberculin Skin Test," Supplement to "Diagnostic Standards and Classification of Tuberculosis and Other Mycobacterial Diseases," revised 1974 by Committee on Diagnostic Skin Testing of the American Thoracic Society Scientific Assembly on Tuberculosis.

Some contacts with negative tuberculin skin test reactions should be considered for preventive therapy. At highest risk are children who are contacts of bacteriologically positive patients and who may be infected but may not yet have converted their tuberculin skin test. These children should receive preventive therapy for 3 months and then be skin tested again. If positive, therapy should be continued for a total period of 12 months; if negative, and exposure has ended, therapy may be discontinued. For adult contacts with negative tuberculin skin test reactions, factors such as the state of infectiousness of the source case and the risk of drug side effects should be considered when prescribing preventive therapy. If therapy is not prescribed, the tuberculin skin test should be repeated in 3 months and therapy prescribed at that time if conversion has occurred.

2. *Positive Tuberculin Skin Test Reactor with Abnormal Chest Roentgenogram.* Persons with past tuberculous disease not previously treated by adequate chemotherapy and tuberculin skin test reactors with roentgenographic findings consistent with nonprogressive tuberculous disease should receive preventive therapy. The rate of reactivation in such groups, if untreated, has been observed to range between 1.0 per cent and 4.5 per cent per year.

3. *Newly Infected Persons.* The risk of developing tuberculous disease for the newly infected is about 5.0 per cent during the first year after infection. Because this excess risk is concentrated in the first year or so, the term, "newly infected persons," should be applied only to those who have had a tuberculin skin test conversion within the past 2 years.

Changes in tuberculin products and differences in the techniques of administration and reading can result in considerable variation in tuberculin skin test results. Therefore, a converter should be defined as a person whose tuberculin skin test reaction has increased by at least 6 mm from less than 10 mm induration to greater than 10 mm. Unless it is reasonably certain that a standard tuberculin has been given with skill and care on both occasions, it may be wise not to consider as newly infected those persons with "borderline conversions."

The so-called "booster effect" should also be taken into account. Because delayed hypersensitivity to tuberculin may gradually wane over the years, a tuberculin skin test given after some time has elapsed since sensitization may be read as negative or doubtful. The stimulus of that test may cause a "boost" in the size of reaction to a repeat test within a year or two, thereby causing an apparent conversion. The booster effect occurs rarely in children, increases in frequency with age, and is seen most frequently in persons over 50 years of age. Therefore, conversions among older persons should be interpreted with caution as signifying new infections.

4. *Special Clinical Situations.* To a varying degree, the following situations increase the risk of developing tuberculous disease and may require preventive therapy in the infected: (a) prolonged therapy with adrenocorticoids, (b) immunosuppressive therapy, (c) some hematologic and reticuloendothelial diseases, such as leukemia or Hodgkin's disease, (d) diabetes mellitus, (e) silicosis, and (f) after gastrectomy.

There is no evidence at this time that continuing

preventive therapy in these situations for more than one year is beneficial.

5. *Other Positive Reactors.* Among persons less than 35 years of age who are positive tuberculin reactors, even in the absence of one of the 4 additional risk factors (such as contacts or converters) listed above, the benefit of INH therapy in preventing tuberculosis clearly outweighs the risk of hepatitis. Preventive therapy is mandatory for positive reactors through age 6 years and highly recommended to age 35 years unless there are contraindications to the use of INH, as listed below.

Among positive tuberculin reactors aged 35 years and more, the risk of hepatitis precludes the routine use of preventive therapy unless one of the 4 additional risk factors (such as contacts or converters) listed above is present. Thus, persons 35 and more with normal chest roentgenograms and no other risk factors (1, 3, or 4) are not, as a group, recommended for preventive therapy. Rather, they should be considered for preventive therapy on an individual basis in situations where there is a likelihood of serious consequences to contacts who may become infected. Examples are persons who live in a closed environment, who work with groups of infants or children, or who work with patients having impaired immune systems.

Screening Procedures

Before INH for preventive therapy is started, the following screening procedures should be carried out:

1. Rule out bacteriologically positive or progressive tuberculous disease. Every person who is a positive reactor should have a chest roentgenogram taken. If there are findings consistent with pulmonary tuberculous disease, further studies—medical evaluation, bacteriologic examinations, and comparison with previous roentgenographic findings—should be made to rule out progressive disease. This is because persons with progressive or bacteriologically confirmed tuberculous disease require more intensive chemotherapy than is given for preventive therapy.

2. Question for a history of INH administration to exclude those who have had an adequate course of the drug.

3. Ascertain the presence of contraindications to the administration of INH for preventive therapy, which are: (a) previous INH-associated hepatic injury, (b) severe adverse reactions to INH, such as drug fever, chills, and arthritis, and (c) acute liver disease of any etiology.

4. Identify patients for whom preventive therapy is not contraindicated but in whom special attention is indicated by the following:

(a) Concurrent use of any other medication on a long-term basis (in view of possible drug interactions)

(b) Use of diphenylhydantoin, the dosage of which may need to be reduced to avoid diphenylhydantoin toxicity. This is because in some individuals INH may decrease the excretion of diphenylhydantoin or may enhance its effect.

(c) Daily use of alcohol, which may be associated with higher incidence of INH hepatitis.

(d) Previously discontinued INH because of possible but not definitely related side effects, e.g., headaches, dizziness, nausea, etc.

(e) Possibility of current chronic liver disease.

(f) Pregnancy. Although no harmful effects of INH

to the fetus have been observed, it is prudent to prescribe only therapeutically necessary medications during pregnancy. Preventive therapy generally should be started after delivery. The increased risk of tuberculosis for new mothers is during the postpartum period, not during pregnancy.

Motivating and Monitoring Individuals

With adequate motivation, most individuals usually accept and stay on INH for the full course of treatment. Enthusiasm and encouragement by the physician, nurse, and other health personnel involved are key factors. At the beginning of a course of preventive therapy, the primary care provider should instruct and motivate the individuals and the parents of children who are to receive INH as to the disease process, necessity for treatment, and the importance of recognition and prompt reporting of certain signs and symptoms. Continuing and additional support in such motivation must be given by health personnel. Patients should be helped to develop their own systems of reminders to take drugs daily. Maintaining drug schedules should be made easier for patients by removing obstacles to getting to clinics or obtaining drug refills. Subsequently, there should be regular office, clinic, or home visits or telephone calls to insure the patient's understanding of the need for continued treatment and the importance of immediate reporting of any signs or symptoms of toxicity. Individuals receiving preventive therapy or a responsible adult in a household with children on preventive therapy should be questioned carefully at monthly intervals for the following:

1. Symptoms consistent with those of liver damage or other toxic effects: that is, unexplained anorexia, nausea, or vomiting of greater than 3 days' duration, fatigue or weakness of greater than 3 days' duration, persistent paresthesia of the hands and feet.

2. Signs consistent with those of liver damage or other toxic effects: that is, persistent dark urine, icterus, rash, elevated temperature of greater than 3 days' duration without explanation.

3. Other signs and symptoms the patient may report.

The use of a standardized form for interviewing at each individual visit will help insure alertness to all signs and symptoms, expedite the interview process, and provide for standardized data collection. Individuals should be advised that immediately on development of any such signs or symptoms during preventive therapy, they should discontinue the drug and report to the clinic or primary care provider for evaluation.

Monitoring by routine laboratory tests (e.g., serum glutamic oxaloacetic transaminase [SGOT], serum glutamic pyruvic transaminase, serum bilirubin, and alkaline phosphatase) is not useful in predicting hepatic disease in INH recipients and therefore is not recommended. However, in evaluating signs and symptoms such tests are mandatory. Preventive therapy should be reinstituted only if biochemical studies are normal and signs and symptoms are absent.

In some instances, an SGOT may be obtained for some reason other than the presence of signs or symptoms. If the result of this test does not exceed three times normal and no signs or symptoms have developed, the drug may be continued with caution and careful continued observation. If the level exceeds three times normal, the decision to continue INH should be based

on careful evaluation for liver damage and the reason for preventive therapy.

Preventive therapy for tuberculous infection with INH is an effective tool in tuberculosis control. It is a preventive health measure which benefits the infected person as well as a valid public health measure for the community. Its continued use should be encouraged.

(Prepared by Peter B. Barlow, Martin Black, Donald L. Brummer, George W. Comstock, I. Nathan Dubin, Philip Enterline, Merle L. Gibson, George E. Hardy, Jr., John A. Harrel, Robert F. Johnston, Donald C. Kent, Beverly A. Marvin, Nancy C. McCaig, Jerry R. Mitchell, James W. Mosley, Frances R. Ogasawara, Hans Popper, Lee B. Reichman, and Hyman J. Zimmerman.)

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Current Trends

NEW ACTIVE TUBERCULOSIS CASES — United States, 1974

Reports from State health departments, based on provisional information, indicate that 30,210 new cases of tuberculosis were reported for the United States during 1974, a decline of 2.5 percent from 1973. The case rate decreased by 3.4 percent from 14.8 per 100,000 population in 1973 to 14.3 in 1974. In 35 states, the 1974 case rate was lower than the final 1973 rate; in 14 states and the District of Columbia the rate was higher; and in one state the rate remained the same. Case rates ranged from a high of 43.2 in Hawaii to a low of 2.7 in Nebraska.

(Reported by Tuberculosis Control Division, Bureau of State Services. CDC.)

REPORT F

Subject: Reporting an M.D. for Suspected Drug Abuse to the North Carolina Board of Medical Examiners Referred to: Reference Committee No. 1

The September 29, 1974, meeting of the Executive Council received and approved a resolution from the Committee on Drug Abuse as follows:

WHEREAS, as of April 1974 the Board of Medical Examiners may submit names of M.D.'s for a non-criminal confidential investigation to the North Carolina Drug Authority, and

WHEREAS, this confidential investigation may lead to the Board of Medical Examiners authorizing continuation of practice under treatment conditions, and,

WHEREAS, unprofessional conduct involves personal abuse and abuse of prescribing privileges, let it be,

RESOLVED, that it is an act of charity to report a fellow M.D. for suspected drug abuse to the North Carolina Board of Medical Examiners. Not doing this is to wish your fellow M.D. to further self-destruction and failure to provide quality care for his patient.

REPORT G

Subject: Common Hazards in the Working Environments and Information on Occupational Health and Safety Items

Referred to: Reference Committee No. II

The September 29, 1974, meeting of the Executive Council accepted a report from the Committee on Occupational and Environmental Health on condition that approval of its proposals makes no impact on the current previously approved budget.

The report is as follows:

WHEREAS, many physicians in North Carolina are not fully aware of the common hazards in the working environments of their patients, and

WHEREAS, it is the responsibility of the North Carolina Medical Society to provide information and encourage communication concerning potential industrial exposures, and

WHEREAS, the Occupational Safety and Health Act of 1970 has now been implemented in North Carolina by the North Carolina Department of Labor, and

WHEREAS, this act deals directly with the health and safety of persons employed in industries in this State, and

WHEREAS, health standards under the Occupational Safety and Health Act will require medical examinations for evaluation of the effects of hazardous exposures within the work environment, and

WHEREAS, physicians will be consulted in regard to correction of work place hazards and therefore must be knowledgeable about these hazards and techniques for examination and identification of occupational diseases, be it therefore,

RESOLVED, by the Committee on Occupational and Environmental Health:

(1) That the North Carolina Medical Society provide the widest possible dissemination of information on occupational health and safety items through publications to its membership.

(2) That this include the *North Carolina Medical Journal*, the Public Relations Bulletin, President's Newsletter, special flyers and publications, redistribution of the Policy Statement of the North Carolina Medical Society on Occupational Health and preparation of an updated catalogue of publications, films and any other related items available at the State Society Headquarters for local and county society usage.

(3) That the Occupational and Environmental Health Committee of the State Medical Society recommend that a program be presented on recognition of common occupational hazards in North Carolina at the State Medical Society meeting in 1976.

(4) That the North Carolina Medical Society sponsor a group of resource physicians of the Society to be available to interested groups or county medical societies as speakers for explaining specific hazards and their consequences.

(5) That this group of speakers being listed by the Committee on Occupational and Environmental Health be available at all times in the Office of the Executive Director of the State Medical Society and that this list be available to all members of the Society.

(6) That the Committee on Occupational and Environmental Health recommend that the North Carolina Medical Society act as a co-sponsor for the program on occupational medicine to be presented by Dr. Leon-

ard Goldwater at Duke University on February 7 and 8, 1975, for industrial and family physicians. Further, that the North Carolina Medical Society look favorably on co-sponsoring other programs of this type as they occur.

REPORT H

Subject: Restructuring of the Committee on Blue Shield
Referred to: Reference Committee No. I

(Intent of Report H accomplished by Item 3, Report Q, Report of the Committee on Constitution and Bylaws. See Page .)

REPORT I

Subject: Acupuncture Therapy Regarded as the Practice of Medicine

Referred to: Reference Committee No. II

The February 2, 1975, meeting of the Executive Council received a recommendation from the Committee on Legislation regarding a statement on acupuncture. The Council approved the proposed statement of Society policy as follows:

"It is the conviction of the North Carolina Medical Society that acupuncture therapy should be regarded as the practice of medicine in an experimental phase permissible only in investigational settings."

The Executive Council also received information, at the meeting, from the Board of Medical Examiners to the effect that the Board of Medical Examiners has unanimously held the practice of acuptuncture to be construed as the practice of medicine approximately eighteen months ago.

REPORT J

Subject: Transfer of Jones County from Lenoir-Greene-Jones County Medical Society to Craven-Pamlico County Medical Society

Referred to: Reference Committee No. I

(Same as Item 5, Report Q, Report of the Committee on Constitution and Bylaws. See Page 49.)

REPORT K

Subject: Suggested Public Relations Policy Statement
Referred to: Reference Committee No. I

The Committee on Public Relations, at the February 2, 1975, meeting of the Executive Council, presented a suggested Public Relations Policy Statement with a motion for acceptance being passed by the Executive Council.

The Statement is as follows:

Definition

Public relations means: **DOING THE RIGHT THING . . . AND THEN LETTING THE PUBLIC KNOW YOU ARE DOING IT.** Public relations is a way of thinking, translated into action . . . or better, *community service*.

Public relations is not a high powered publicity campaign. It is not a program designed to splash our present medical system loudly and flamboyantly before the public via the state's newspapers and broadcast outlets. And, public relations is not created to "whitewash" imperfections.

For success it is important that public relations efforts, Medical Society public relations, be based on sincerity — an honest desire to do the best possible

job in the best possible way. Hence, COMMUNITY SERVICE, is the overriding theme of the North Carolina Medical Society public relations endeavors.

Purpose

The ultimate purpose of the North Carolina Medical Society's public relations program is to earn and retain as many "friends of medicine" as possible. It is desirable that the term "friends of medicine" includes every possible group and individual in the State of North Carolina.

Goals

It is important that the North Carolina Medical Society public relations program strives to accomplish two primary goals:

1. Educate the general public of the activities and pertinent issues concerning our present medical care system.
2. Assure conveyance of the correct image of medicine and the practicing physician.

Objectives

North Carolina Medical Society public relations endeavors must focus on two critical objectives:

1. Plan, establish and administer a public relations program that is statewide in scope, and is *tailored to local needs* by serving as a source of ideas, materials and manpower;
2. Include all levels of private medicine in the state, especially county medical society members because medical care in the community is the basic level of physician-public contact as well as being the most effective means of approaching the media, establishing contact and then maintaining good media relations.

North Carolina Medical Society Implementation

The public relations program of the North Carolina Medical Society is implemented along two different routes (most of which is already in various stages of implementation):

1. INTERNAL — to keep membership informed and involved
 - a. Publish a *Public Relations Bulletin*
 - b. Distribute the *President's Newsletter*
 - c. Assist county medical society public relations chairmen and representatives in the development of COMMUNITY SERVICE programs
 - d. Prepare, publish and distribute timely information on topics of interest
 - e. Prepare and make available materials and programs for county societies
 - f. Provide increased assistance to county medical societies upon request
2. EXTERNAL — to keep the public informed and to stimulate provision of services to meet health needs
 - a. Promote use of authoritative television and radio programs such as MEDIX (TV), FEELING GOOD (TV) AND HEALTH CARE INFORMATION (radio)
 - b. Prepare, publish and distribute informative materials designed to inform the public and increase health consciousness
 - c. Assist in the planning and implementation of COMMUNITY SERVICE projects
 - d. Serve as the spokesman on issues to help the public receive balanced information on medical matters affecting them

e. Serve as the liaison spokesman to related state organizations such as the North Carolina Rescue Squad Association, North Carolina Science Club, etc.

f. Prepare frequent news releases for all communications media

County Medical Society Implementation

The grassroots key to North Carolina Medical Society public relations endeavors is county medical society involvement and activity. It is here that the COMMUNITY SERVICES are most important and appreciated because communities look to physicians to provide leadership in the provision of needed health services.

Thus, concerned and well-informed physicians working individually and collectively through county medical societies is the foundation of all public relations activities.

For good public relations on the county level, it is important to identify the needs, determine and then implement a plan of action with county medical society approval to meet the needs.

Approaches

Effective county society public relations programs should be implemented with two equally important factors as guidelines:

1. DEVELOP AND MAINTAIN IMPROVED RELATIONS WITH REPRESENTATIVES OF THE COMMUNICATIONS MEDIA

a. Hold medical-press meetings to discuss mutual problems, roles, goals, and areas of misunderstanding. Invite not only the editors and representatives from radio and television, but also who cover medical areas. It may be desirable to invite others to these meetings such as hospital administrators, trustees, representatives from the chamber of commerce, etc.

b. Designate a spokesman in your county medical society to give prompt, accurate replies to queries and also to supply the communications media with necessary and timely medical information. His name, address and telephone numbers should be made available to the local media so they will know who to contact and where to contact him. The county medical society spokesman should visit communications media representatives to get to know them personally.

c. Keep channels of communication open by:

- 1) Cooperating with newsmen
- 2) Being truthful and honest
- 3) Respecting the media representatives' desire for timeliness in news
- 4) Avoiding hedging after giving a story; anonymity helps no one
- 5) Asking no favors (cooperation and trust will make them available)
- 6) Being accurate and fair (newsmen will respect confidences)
- 7) Saying "Thank you" always
- 8) Giving awards and/or citing media for public service activities

2. PROVIDE LEADERSHIP IN THE PROVISION OF NEEDED COMMUNITY SERVICES

a. Encourage each physician to increase his efforts to prevent problems of accessibility for his patients and to provide improved programs in patient education

b. Identify local health needs and promote the community leadership needed to meet these needs

Suggested Programs That Have Worked

1. Implement a Non-Emergency Medical Information Telephone Number (listed in the front of the telephone directory, and in the yellow pages, if possible).
2. Provide information on existing medical services available to newcomers through Chamber of Commerce or "Welcome Wagon" programs. Information provided can include telephone information numbers, a listing of ambulance services, hospitals, other health services, pharmacies and health insurance outlets. Also include an explanation of types of medical services available in the town (include specialties).
3. Consider the establishment of free blood pressure screening clinics in public places as well as other related health examination campaigns.
4. Make free courses available in coordination with area educational bodies on such topics as "Family Planning Clinics," "Child Health," etc.
5. Make available to the public a list of medical services in the area through both private and/or public channels.
6. Organize and sponsor immunization and disease protection programs.
7. Present awards to citizens on behalf of local medical society recognizing a person or group for their health efforts.
8. Make medicine's views available on such matters as cost of health care, etc., through media and through presentations to area civic clubs, schools and churches. Tell how national issues affect the local population.
9. Have spokesmen available for local television station, radio station, civic clubs, etc.
10. Develop a program to provide physical examinations to local athletic teams.
11. Provide programs on designated topics such as accident prevention, child safety, health problems, etc.
12. Distribute written material and films, available from State Medical Society, AMA and other information outlets for program use in schools, libraries, physicians' offices, hospital lobbies, etc.
13. Promote the viewing of public service television and radio programs such as MEDIX on local television outlets.
14. Establish comprehensive and coordinated programs for patient education for use in hospitals, physicians' offices, etc.

LET THE NORTH CAROLINA MEDICAL SOCIETY KNOW HOW IT CAN HELP YOU BE OF MORE SERVICE TO YOUR COMMUNITY!!

REPORT L

Subject: Proposed Amendment to the Medical Practice Act

Referred to: Reference Committee No. II

The April 13, 1975, meeting of the Executive Council reconsidered the question of the proposal to change the N. C. General Statutes to permit nurses or physician's assistants to prescribe, compound and dispense drugs under direction and supervision of a physician and approved a motion to accept the revised draft of the proposed amendment to the Medical Practice Act. The revised draft of the proposed amendment, including additional wording suggested by the Executive Council is as follows:

*A BILL TO BE ENTITLED
AN ACT TO LIMIT THE PRESCRIPTION, COM-*

POUNDING AND DISPENSING OF DRUGS BY CERTAIN PERSONS APPROVED BY THE BOARD OF MEDICAL EXAMINERS The North Carolina General Assembly enacts:

Section 1. Chapter 90 of the North Carolina General Statutes is amended by adding a new section to read as follows:

"90-18.1. *Limitation on physician's assistants and registered nurses authorized to prescribe, compound and dispense drugs.* Any registered nurse or assistant to a physician who is approved to perform medical acts under the provisions of G.S. 90-18 is authorized to prescribe drugs under standing orders of the supervising physician, if such function is specifically approved for that person by the Board of Medical Examiners, in accordance with such other safeguards and regulations as promulgated by such Board. Any such person is authorized to compound and dispense drugs under standing orders of the supervising physician, if approved by the Board, and if such function is performed at a clinic or other health facility located farther than twelve miles from a pharmacy. Any such person authorized to prescribe drugs shall be identified by a number assigned by the Board and such number shall be indicated in all prescriptions both oral and written."

Section 2. This act shall become effective upon ratification. It was also pointed out by the Medical Society's Legal Council that there is another related section of the General Statutes in a section outside of the Medical Practice Act, administered by the Department of Agriculture, that needs to be revised to accommodate the Definition of a Practitioner. The Council approved the modification of that Statute to read as follows:

Practitioner means: A physician, dentist, veterinarian, or other person licensed, registered or otherwise permitted to distribute, dispense, or conduct research with respect to or to administer a drug so long as such activity is within the normal course of professional practice or research in this State.

REPORT M

SUBJECT: Recommendations from the Committee on Traffic Safety Relating to Visual Fields for Drivers, Classified Driver's Licensing System, Budget Support for Breathalyzer Program, and Patient's Driving Records

Referred to: Reference Committee No. II

The Executive Council at its April 13, 1975, meeting considered a series of recommendations presented by the Committee on Traffic Safety, and after adding minor wording additions, approved the recommendations as follows:

1. On the recommendation of the Committee on Eye Care, the Committee on Traffic Safety recommends that THE STANDARD FOR VISUAL FIELDS FOR DRIVERS BE THAT "TESTED WITH BOTH EYES OPEN AND WITH AND WITHOUT GLASSES THE APPLICANT SHOULD HAVE A MINIMUM VISUAL FIELD OF 30° TO EITHER SIDE OF FIXATION IN THE HORIZONTAL MERIDIAN."

2. The Committee on Traffic Safety recommends that THE NORTH CAROLINA MEDICAL SOCIETY SUPPORT LEGISLATION CREATING A CLASSIFIED DRIVER'S LICENSING SYSTEM IN NORTH CAROLINA. The classified driver's licensing system would include in Class A — any vehicle; Class B —

any vehicle over 2,400 lbs.; Class C — a regular automobile license; and Class M — Motorcycles.

3. The Committee on Traffic Safety recommends that THE NORTH CAROLINA MEDICAL SOCIETY GO ON RECORD AS FAVORING A SUPPLEMENTAL BUDGET REQUEST TO SUPPORT THE BREATHALYZER PROGRAM IN THE DEPARTMENT OF TRANSPORTATION.

4. The Committee on Traffic Safety recommends that THE NORTH CAROLINA MEDICAL SOCIETY BELIEVES THAT A PATIENT'S DRIVING RECORDS SHOULD BE A PART OF THE INFORMATION SUPPLIED TO THE PHYSICIAN WHEN EVALUATING A PATIENT'S ABILITY TO DRIVE, AND AND FURTHER, THAT ALL STATE AGENCIES SHOULD COOPERATE IN PROVIDING INFORMATION FOR BONAFIDE MEDICAL RESEARCH IN THE AREA OF DRIVING.

REPORT N

Subject: Professional Liability Insurance Problems
Referred to: Reference Committee No. 1

The April 13, 1975, Executive Council meeting received and approved several recommendations from the ad hoc Committee to Study Professional Liability Insurance Problems, as follows:

1. That the Medical Society should continue to support the concept of a Professional Liability Reinsurance Exchange as encompassed in HB 74.

2. That the Medical Society should support a bill that would create a Legislative Study Commission to study professional liability insurance problems in North Carolina (HB 567).

3. That in the long run, a "claims made" type of policy would not be necessarily detrimental to physicians. That the Society should support the "claims made" policy if other approaches to the professional liability insurance problem fail to be resolved by July 1, 1975, assuming that no "on occurrence" type policy is available.

In addition to approval of the above recommendations, the Council approved a motion that the ad hoc Committee be directed to continue its studies, specifically, the plans now underway in states such as Maryland and Idaho, to see what can be done in North Carolina in the future.

REPORT O

Subject: Report of the Committee on Medical Education, requested by the May 1974 House of Delegates (Report H—1974)

Referred to: Reference Committee No. 1

The April 13, 1975, Executive Council meeting accepted a report from the Committee on Medical Education, presented in response to the request of the May 1974 House of Delegates, for forwarding to the 1975 House of Delegates. The report was as follows:

Report H, as passed by the House of Delegates of the North Carolina Medical Society in May 1974, provides that "150 hours of continuing education per three years be required of each member of the State Medical Society, reportable on an annual basis." This same report requested the Committee on Medical Education "to study and recommend methods of awarding credits, processing and recording replies, managing cases of

hardship and noncompliance," and to report their findings to the House of Delegates in 1975.

Awarding Credits

In meeting the 150 hour requirement, it was decided by the Committee that this requirement will be considered as satisfied if a member qualifies for the Physician's Recognition Award of the American Medical Association or if he meets the continuing education requirements of the American Academy of Family Practice. If he does not qualify under one of these two categories, a member's 150 hours are to be classified according to one of the following two categories⁽¹⁾.

A. Courses or activities sponsored or approved by recognized medical education centers and agencies (university-based, AHEC, etc.), medical societies (local, North Carolina, and AMA), or medical specialty and scientific societies.

B. Self-instruction, E.G., audio tapes, programmed self-instructional materials, videotapes, reading medical textbooks and journals, teaching, presenting or publishing professional papers or exhibits.

All 150 hours may be as defined under Category A. A maximum of 75 hours during a three year period may be as defined under Category B. As soon as the continuing Medical Education Accreditation Program of the Society is operational, any continuing education activity offered as part of an accredited program will qualify under Category A.

Processing and Recording Replies

The Committee on Medical Education has designed and approved the use of a pocket size card form for use by each member in recording his personal involvement in continuing medical education activities. This form is to be submitted each year along with the payment of annual dues. Provision is made for indicating whether an activity falls under Category A or Category B, as defined above.

Every three years, each member must complete that portion of the form which certifies that he has completed 150 hours of continuing medical education during the previous three years, as required in the Bylaws.

This form is being printed at the present time, and will be distributed to all members of the Society in the near future.

Cases of Hardship and Noncompliance

Each case of hardship and or *request for exemption* from the continuing medical education requirements will be handled on an individual basis, in response to a request directed by a member to the Committee on Medical Education.

As yet the committee has not arrived at definitions of hardship nor classifications of exemption.

Members not complying with the continuing medical education requirement and not exempted from compliance will be referred to the Executive Council.

REPORT P

Subject: An Expression of Appreciation to Donald Brock Koonce, M.D.

Referred To: Reference Committee No. 1

The April 13, 1975, Executive Council accepted with great regret the resignation of Donald B. Koonce, M.D., as a Delegate to the American Medical Association and

⁽¹⁾ Committee Minutes, September 26, 1974.

adopted a motion expressing the appreciation of the Executive Council and requested the House of Delegates to make a similar expression.

The Expression of Appreciation is as follows:

A physician of uncommon ability and great stature is a credit to our profession and a blessing to mankind. Such a man is Donald Brock Koonce, of Wilmington, North Carolina.

A member of this Society since 1934, he has served it faithfully, effectively and with distinction in many capacities, notably as President in 1956-57, as Speaker of the House 1959 to 1962 and 1965 to 1969, and as a Delegate to the American Medical Association. His performance of official duties is characterized by a rare combination of candor, fairness and statesmanship.

As a member of the House of Delegates of the American Medical Association from 1965 until his recent resignation, Doctor Koonce was always held in the highest esteem. In addition, he served as a highly respected member of the Joint Commission for Accreditation of Hospitals during the past several years.

The House of Delegates of the North Carolina Medical Society desires to pay tribute to Doctor Donald Koonce at this time for his substantial and outstanding contributions and expresses to him herewith the deep appreciation and lasting affection of the membership of this Society.

REPORT Q

Subject: Proposed changes in the Constitution and By-laws.

Referred to: Reference Committee I.

(See Page 49, & 75, Report of the Chairman of the Committee on Constitution and Bylaws.)

REPORT R

Subject: Physician Participation in the Medicaid Program

Referred to: Reference Committee No. I

The April 13, 1975, Executive Council approved a motion as follows:

"That the Executive Council request that the House of Delegates take official action urging and requesting that all physicians participate in the North Carolina Medicaid Program."

REPORT S

Subject: Consideration of applications for Hospital Privileges by licensed Podiatrists

Referred to: Reference Committee No. II

A January 30, 1975, letter from the Legal Counsel for the North Carolina Podiatry Society requested an opportunity for representatives of the Podiatry Society to meet with the Executive Committee of the North Carolina Medical Society for consideration of the question of extending hospital privileges to licensed Podiatrists.

Representatives of the North Carolina Medical Society met with representatives of the North Carolina Podiatry Society in Raleigh on April 10, 1975.

The April 13, 1975, meeting of the Executive Council considered the request of the Podiatry Society for a statement of policy on the question of extending hospital privileges to licensed Podiatrists, and approved the following motion:

"That this Council go on record as recognizing the validity of a hospital staff considering approval of the membership of a podiatrist on the staff of the hospital

on an individual basis, with qualifications and functions in accord with published guidelines of the Joint Commission on Accreditation of Hospitals and the American Academy of Orthopaedic Surgeons."

RESOLUTIONS

SPEAKER CARR: Next is the referral of the numbered resolutions which arise from the counties. They also are in your packets. I know of no particular changes in them. They are numbered and the Reference Committee to which they are assigned are enumerated.

Do I hear a motion that these resolutions be accepted by the House as its business and referred to these Reference Committees as assigned?

DR. THORNTON R. CLEEK (Randolph County): So moved.

(The motion was duly seconded from the floor.)

SPEAKER CARR: It has been moved and seconded. Any further discussion? All in favor say "ayes"; opposed "no." The motion is carried.

Resolution: 1

Introduced by: Edgecombe-Nash County Medical Society

Subject: Reference Committees

Referred to: Reference Committee No. I

WHEREAS, the House of Delegates of the North Carolina Medical Society is the legislative body for our Society, and

WHEREAS, free and open debate is necessary in order for this body to adequately evaluate matters which are presented to it, and

WHEREAS, Reference Committees tend to limit debate and inject influence of the Administrative branch of the Society's governing body into matters which are the concern of the Legislative branch.

THEREFORE, BE IT RESOLVED that Reference Committees be abolished and that matters presented to the North Carolina Medical Society for legislative action be openly debated and decided upon at open meetings of the House of Delegates of the North Carolina Medical Society without the restraining influence of the Administrative branch of the Society.

Resolution: 2

Introduced by: Lincoln County Medical Society

Subject: Cash Reserves of North Carolina Medical Society

Referred to: Reference Committee No. I

WHEREAS, in the Report of the Transactions of the North Carolina Medical Society for the May 1974 Annual Meeting the total operating budget adopted for 1974 is \$506,000; and

WHEREAS, the North Carolina Medical Society headquarters building and grounds are free and unencumbered; and

WHEREAS, the North Carolina Medical Society is to receive approximately \$29,300 annually for eight more years as payment and interest on the sale of real estate; and

WHEREAS, the Report of Transactions shows that \$92,900 has been set aside as an operating reserve; and **WHEREAS**, it is stated on page eight of the Report that "this new reserve account is intended to eventually equal one year's operating cost"; and

WHEREAS, computations from the figures available

in the Report of the Transactions indicate that there will be in cash reserves and operating reserve in excess of \$210,000 by the end of 1975;

THEREFORE, BE IT RESOLVED that the Lincoln County Medical Society in regular session on December 12, 1974, request and petition the North Carolina Medical Society House of Delegates to resolve that henceforth the North Carolina Medical Society shall not accumulate over and above its annual requirement for operation any operating reserves and/or cash reserves in excess of twenty-five (25) percent of its operating budget.

Resolution: 3

Introduced by: Forsyth County Medical Society
Subject: Establishment of a Section on Emergency Medicine

Referred to: Reference Committee No. 1

WHEREAS, the field of Emergency Medicine has become a specialty unto itself, and

WHEREAS, many physicians (11 in this county and 100 in the state) devote their full time and effort to the practice of Emergency Medicine, and

WHEREAS, the first residency training program has Emergency Medicine in the state of North Carolina has become established in this county, and

WHEREAS, representation of this discipline in North Carolina Medical Society will be of considerable benefit for all concerned, and

WHEREAS, precedent for such action has been set by Sections on Emergency Medicine in the American Medical Society, Southern Medical Society, and many state medical societies, such as California, Florida, Michigan, and others,

BE IT RESOLVED that the Forsyth County Medical Society goes on record recommending a Section on Emergency Medicine be established by the North Carolina Medical Society.

Resolution: 4

Introduced by: Edgecombe-Nash County Medical Society

Subject: Creating Improved Communications Between Hospital Staffs Through County and State Medical Societies

Referred to: Reference Committee No. II

WHEREAS, the rapid pace of change in the practice of medicine and the continuing attempts at imposing controls on physicians make it imperative that all physicians be informed about changes or contemplated changes in order to implement them or take action against them, and

WHEREAS, an individual hospital staff might be singled out as a test case for proposed changes without other hospital staffs having knowledge of the action which might later affect them, and

WHEREAS, a broader base of experience can be drawn upon in arriving at solutions if all are informed, therefore,

BE IT RESOLVED that the North Carolina Medical Society inform every member of the Society through the President's monthly message or a letter from the Executive Secretary whenever there are attempts by a hospital administrator, the Joint Commission on Accreditation of Hospitals, or a federal agency to impose new regulations or controls over a hospital staff if the request is made through a County Medical Society.

Resolution: 5

Introduced by: Edgecombe-Nash County Medical Society

Subject: Fiscal Versus Quality Stands

Referred to: Reference Committee No. II

WHEREAS, in 1965 the federal government adopted programs to finance medical and health care costs for certain groups of citizens, and

WHEREAS, these and other programs by the federal government have had a severe inflationary impact on health care costs, and

WHEREAS, the federal government has failed to exercise realistic measures in applying cost containment to these programs, and

WHEREAS, the North Carolina Medical Society believes the most recent action by the federal government at cost containment, through Professional Standards Review Organizations, will also fail, and

WHEREAS, PSRO carries with it certain potential for far-reaching adverse effects upon the quality of medical care in this nation and upon the professional freedom of physicians, now therefore,

BE IT RESOLVED that the North Carolina Medical Society does

1. HEREBY recognize that any "norms," "standards," "profiles" or "criteria" by whatever name, by whomever authored, have become, and will continue to be, primarily "yardsticks" or instruments for measurement of fiscal concern.

2. HEREBY renounce that such said standards, can, in and of themselves, be valid measurements of quality. Quality health care rendered by professional providers of services is often an abstract, imprecise, variable entity that can rarely lend itself to codified documentation.

Resolution: 6

Introduced by: Edgecombe-Nash County Medical Society

Subject: Medical Audit

Referred to: Reference Committee No. II

WHEREAS, various groups have evolved mechanisms for medical audit (Quality Assurance Program, Trustee-Administrator-Physician, Hospital Admissions Survey Program, Professional Activity Study/Medical Audit Program, Utah Professional Review Organization, etc.) by constructing parameters which are allegedly appropriate, and

WHEREAS, quality of health care rendered by professional providers of services is often an abstract, imprecise, variable entity that can rarely lend itself to codified documentation, and

WHEREAS, such "norms," "standards," "criteria" and "profiles" are primarily concerned with fiscal matters, and

WHEREAS, such "norms," "standards," "criteria" and "profiles" may lend themselves to misinterpretation by plaintiff attorneys and the courts as representing valid measurements of quality, and

WHEREAS, physicians embrace assessment of quality of medical care, but will not subvert considerations of quality to fiscal concerns, therefore be it

RESOLVED that the North Carolina Medical Society rejects the concepts of QAP, TAP, HASP, PAS/MAP, UPRO, etc. for determination of quality care and strongly urges its membership to oppose the implementation of such programs by their hospital staffs for this purpose.

Resolution: 7

Introduced by: Edgecombe-Nash County Medical Society

Subject: Certification and Utilization Review

Referred to: Reference Committee No. II

WHEREAS, the Professional Standard Review Organizations law and the recent Code of Federal Regulations (Federal Register) have altered the role of physicians in the treatment of hospital patients, therefore be it

RESOLVED that the North Carolina Medical Society strongly urges its members thusly:

Since Certification and Utilization Review establish contractual relationships which provide for compliance with PSRO-type "standards," "norms" and "criteria," the North Carolina Medical Society strongly urges that its members not participate in such Certification and/or Utilization Review.

Resolution: 8

Introduced by: Rutherford County Medical Society

Subject: Repeal of PSRO Law

Referred to: Reference Committee No. II

Because of the use of stereotyped "admission criteria" and "treatment standards," the PSRO law becomes unfair and oppressive upon Physicians' rights in treating patients to the best of their abilities; and because of the punitive nature and unfair appeal procedures inherent in this law, regarding Physicians' judgments concerning hospital admissions;

BE IT RESOLVED that the Rutherford County Medical Society urges repeal of this pernicious law, and invites the North Carolina Medical Society to join it in this appeal.

Resolution: 9

Introduced by: Cleveland County Medical Society

Subject: Medical Malpractice Insurance

Referred to: Reference Committee No. I

WHEREAS, the availability of totally satisfactory medical malpractice insurance to which physicians are accustomed is being threatened; and

WHEREAS, the cost of such inclusive insurance in the United States and North Carolina is apparently destined to become prohibitive; and

WHEREAS, little of the present "medical malpractice insurance dollar" is utilized to compensate truly injured (because of valid medical malpractice) patients; and

WHEREAS, currently proposed (no-fault, workmen's compensation-type, and other plans) substitute forms of "insurance" are not compatible with preservation of the practice of law as desired by members of the legal profession;

THEREFORE, BE IT RESOLVED that the North Carolina Medical Society requests the North Carolina Bar Association to forthwith study the subject of medical malpractice insurance so as to make specific proposals that will preserve the availability of medical malpractice insurance, make it obtainable at reasonable cost, enhance its effective value to the injured, and guarantee the legitimate, time-tested framework desirable for the practice of law when members of the legal profession may be called upon to assist with litigation of valid medical misadventures, and

BE IT FURTHER RESOLVED to communicate constructive recommendations to members of the legal and

medical professions, insurance commissions and insurance carriers, appropriate elected legislative bodies, and the courts and the public.

Resolution: 10

Introduced by: Wayne County Medical Society

Subject: Professional Liability Premium Costs

Referred to: Reference Committee No. I

WHEREAS, it is of increasing concern that professional liability premiums are rising, corrective measures should be introduced to curb the astronomical settlements and physician's premium rates.

Recommendations to this end are suggested and supported by Wayne County Medical Society that:

(1) There should be a dollar ceiling limit in recovery similar to Workmen's Compensation. Physicians or patients would carry insurance under which a patient could collect for malpractice, based on fixed-injury damage rates. There would be no trials, and fancy returns to lawyers would be avoided. Arbitration clauses would remove medical-hospital malpractice cases from the courts. They no longer belong there. Emotions are too easily aroused to gamble with a fair determination at the hands of laymen serving as jurors or from judges with no educational background in medicine. Patients should agree to an arbitration agreement before medical or surgical service is begun.

(2) Legislature should study medical liability practices.

(3) Ceiling on lawyer's fee; eliminate contingency.

BE IT RESOLVED that a study of the ever escalating professional liability insurance program include arbitration, ceiling on lawyer's fee and active N. C. Legislature participation.

Resolution: 11

Introduced by: Wayne County Medical Society

Subject: Uniform policy of vendor payments under Medicare and Medicaid throughout the State

Referred to: Reference Committee No. II

RESOLVED that the Wayne County Medical Society recommends a uniform policy of vendor payments under Medicare and Medicaid be applied throughout the state regardless of geopolitical boundaries.

Resolution: 12

Introduced by: Committee on Medical Education

Subject: Continuing Medical Education

Referred to: Reference Committee No. I

WHEREAS, in May 1974, it was resolved by the House of Delegates of the North Carolina Medical Society that "a minimum of 150 hours of continuing education per three years be required of each member of the North Carolina Medical Society," and

WHEREAS, by this same resolution, the Committee on Medical Education of the North Carolina Medical Society was directed "to study and recommend methods of awarding credits, processing and recording replies, and managing cases of hardship and noncompliance," and

WHEREAS, the Committee on Medical Education of the North Carolina Medical Society, after study and deliberation, has concluded that the foregoing resolution makes it incumbent upon the North Carolina Medical Society to promote and assist in the establishment of high quality continuing medical education programs

in community hospitals and other institutions and organizations in North Carolina, and

WHEREAS, it has been demonstrated by other state medical societies that the number of continuing medical education programs will be increased and the quality of continuing medical education programs will be improved through a program which provides for the careful planning, evaluation and accreditation of continuing medical education programs, and

WHEREAS, it has been recommended by the Council on Medical Education of the American Medical Association "that state medical associations plan and implement their own programs . . . of accreditation under a procedure approved and periodically reviewed by the American Medical Association," and that such "accreditation by a state medical association will give essentially the same status to an educational institution or organization as would accreditation by the American Medical Association at the national level,"

BE IT THEREFORE RESOLVED,

(1) that the North Carolina Medical Society apply to the Council on Medical Education of the American Medical Association for recognition as a body approved to accredit programs of continuing medical education in North Carolina, and

(2) that the **ESSENTIALS OF APPROVED PROGRAMS IN CONTINUING MEDICAL EDUCATION**, as prepared by the Council on Medical Education of the American Medical Association and adopted by the House of Delegates of the American Medical Association in June 1970, be adopted by the North Carolina Medical Society as a statement of basic essentials for programs of continuing medical education which are to be accredited by the North Carolina Medical Society, and

(3) that the following three documents

a. **OVERALL PLAN OF THE NORTH CAROLINA MEDICAL SOCIETY FOR SURVEYING AND ACCREDITING QUALIFIED PROGRAMS OF CONTINUING MEDICAL EDUCATION IN NORTH CAROLINA**

b. **ACCREDITATION MANUAL**

c. **GUIDELINES FOR USE IN THE PREPARATION OF ACCREDITATION SURVEY REPORTS**

which were prepared by the Committee on Medical Education of the North Carolina Medical Society and accepted by that Committee at its regular meeting on February 27, 1975, be adopted in principal by the North Carolina Medical Society, as the basic documents to be used, along with the above cited **ESSENTIALS OF APPROVED PROGRAMS IN CONTINUING MEDICAL EDUCATION**, in the Continuing Medical Education Accreditation Program of the Society, and that the Committee on Medical Education be authorized and directed to make such minor modifications in these documents as are necessary to the continued successful implementation of the North Carolina Medical Society's Continuing Medical Education Accreditation Program.

Resolution: 13

Introduced by: Beaufort-Hyde-Martin-Washington-Tyrrell Counties Medical Society

Subject: Chemical Screening Tests by Local or Area Health Departments

Referred to: Reference Committee No. I

WHEREAS, the numerous preventive health programs supervised and directed by health departments

are approved, endorsed, and supported by the Pamlico-Albemarle 5 County Medical Society, and

WHEREAS, the screening tests of blood chemistries constitute judgments in the practice of medicine as to types and numbers of chemical tests in addition to many borderline decisions,

BE IT THEREFORE RESOLVED, that the Pamlico-Albemarle 5 County Medical Society (Beaufort, Hyde, Martin, Tyrrell, and Washington), recognizing that chemical screening tests constitute medical judgments and decisions, does hereby strongly oppose the use of these procedures by local or area health departments within the 5-County area without the specific approval of the Pamlico-Albemarle 5 County Medical Society, and

BE IT FURTHER RESOLVED that a copy of this statement of purpose and resolutions be sent to all health departments in this 5-County area and to the Director of the North Carolina Division of Health Services, Raleigh, North Carolina, and

BE IT FURTHER RESOLVED that the North Carolina Medical Society be urged to adopt a similar resolution as Society policy.

Resolution: 14

Introduced by: Committee on Public Relations

Subject: Suggested Position Paper on Patient Education
Referred to: Reference Committee No. I

WHEREAS, the North Carolina Medical Society recognizes the importance of appropriate patient education as a requisite for quality medical care, and

WHEREAS, successful management of many illnesses cannot be achieved without the necessary patient behavior modification, and

WHEREAS, although the physician is the preferred educator of patients, many other educational methods are now available to supplement his efforts, and

WHEREAS, in each physician's practice, those illnesses which can benefit most from patient education should be identified and appropriate programs of patient education established, now therefore be it

RESOLVED, that patient education exposures be recorded in the medical record, and be it further

RESOLVED, that the provision of appropriate patient education should be included as an integral component of physicians' services.

Resolution: 15

Introduced by: The Durham-Orange County Medical Society

Subject: Use of pound animals in biomedical research and education

Referred to: Reference Committee No. II

WHEREAS, the quality of human life has been improved by application of procedures, techniques, and drugs developed and evaluated in experimental laboratories, and

WHEREAS, such experiments by necessity require the use of animals in experimental situations, and

WHEREAS, thousands of unwanted animals are exterminated in the pounds of the state of North Carolina annually, and

WHEREAS, the disposal of such animals has been the subject of much public discussion, and

WHEREAS, the use of this valuable relatively inexpensive animal resource is necessary for sustaining improvements leading to better health care; therefore,

BE IT RESOLVED that the North Carolina Medical Society go on record supporting a statewide policy which continues to insure that pound animals are directly or indirectly available to the institutions of medical education and medical research; and

BE IT FURTHER RESOLVED that the rights of lawful pet owners should be protected by responsible waiting periods before pounds dispose of such animals; and

BE IT FURTHER RESOLVED that the North Carolina Medical Society supports humane treatment for all animals used in experimental situations, in keeping with current state and federal laws; and

BE IT FURTHER RESOLVED that the North Carolina Medical Society go on record as opposing efforts to restrict the availability of such animals to medical research and medical educational institutions.

Resolution: 16

Introduced by: Mecklenburg County Medical Society

Subject: House Bill 74

Referred to: Reference Committee No. 1

WHEREAS the practice of medicine must be aggressive rather than defensive if patients are to best served; and

WHEREAS courts throughout the nation have rapidly moved to liberal settlements in the field of professional liability, even in highly questionable cases; and

WHEREAS professional liability insurance carriers are threatening to withdraw from the State of North Carolina because of various restrictions, including rate limitations; therefore,

BE IT RESOLVED that the Mecklenburg County Medical Society calls upon the House of Delegates of the North Carolina Medical Society to endorse House Bill 74 which creates a professional liability reinsurance exchange. (This appears to be the only way we can be certain of having continuing professional liability insurance after July 1, 1975);

BE IT FURTHER RESOLVED that we endorse the "claims made" approach for writing professional liability insurance, at least for the moment, and in the absence of any better alternative;

BE IT FURTHER RESOLVED that the North Carolina Medical Society Ad Hoc Committee (John Glasson, Durham; Chalmers Carr, Charlotte; Tom Dameron, Raleigh; Ira Hardy, Greenville, Chairman) investigate the possibilities of the following:

(a) a statewide mutual insurance company to write and offer professional liability insurance;

(b) the no fault insurance concept;

(c) methods for establishing limitations of benefits and contingency fees;

(d) elimination of the ad damnum clause in tort actions;

(e) the use of arbitration as a means of settling claims; and

(f) the possibilities of shortening the period of discovery.

NOMINATING COMMITTEE

SPEAKER CARR: It is now necessary that we recess which is customary for the caucusing of the districts involved for the election of members of the Nominating Committee. Because of the staggering of the districts, it's only necessary for the Second, Sixth and Tenth Districts to caucus and elect a member to the Nominating Committee and report back to us as soon as it's

feasible and comfortable for you to do so.

We now stand in recess so this caucus may be held.

(Whereupon there followed a ten minute recess for the purpose of the caucusing of the three districts listed.)

We have received the nominations from the districts involved to the Nominating Committee, subject to your election.

They are:

Second District, Dr. John Wooten

Sixth District, Dr. Oscar Sapp

Tenth District, Dr. Edward (Pete) Schoenheit

I would like a motion that these nominees from these three districts be elected to the Nominating Committee.

DR. GILBERT: So moved.

(The motion was duly seconded from the floor.)

SPEAKER CARR: It is moved and seconded. Any discussion? All in favor say "aye"; opposed "no." I so declare they are elected.

Unless there is opposition, I recognize Dr. David Welton for the purpose of a Memorial Resolution.

DR. DAVID G. WELTON (AMA Delegate): This is a Memorial Resolution about Amos Neill Johnson, M.D. presented by the North Carolina Delegation to the American Medical Association.

MEMORIAL RESOLUTION

Introduced by: North Carolina Delegation to the American Medical Association

Subject: Amos Neill Johnson, M.D.

WHEREAS, God in His infinite wisdom has removed from our ranks our beloved colleague, AMOS NEILL JOHNSON, M.D., and

WHEREAS, Doctor Johnson was endowed with singular capacities of intellect, character, physical vigor, steadfastness of purpose, love of his fellow man, attributes of leadership, and dedication to his profession, and

WHEREAS, Doctor Johnson developed and utilized these God-given talents to an extraordinary degree, with the benefits of his efforts enuring not only to his family and patient population in Sampson County, but extending throughout the breadth of this state and nation, and

WHEREAS, Doctor Johnson accepted with grace and wore with wisdom, style, and dignity the mantle of leadership in his professional organizations at the state and national levels including the North Carolina Medical Society, American Medical Association, the State and National Academies of Family Physicians, the American Board of Family Practice, and others, and

WHEREAS, Doctor Johnson on countless occasions acted as an able spokesman for medicine and for the welfare of our patients before the public, the news media, the General Assembly of North Carolina, Committees of the Congress of the United States, and other high councils of government, and

WHEREAS, we hold that his life represents an exemplary model of the true and complete physician,

THEREFORE, BE IT RESOLVED that the North Carolina Medical Society expresses its sincere and profound sorrow upon the loss of our esteemed colleague, friend, and leader; that we extend our heartfelt sense of condolence and sympathy to his family and patients, and

BE IT FURTHER RESOLVED, that copies of this Resolution be transmitted to his family, to appropriate news media including the *North Carolina Medical Jour-*

nal, and to the House of Delegates of the American Medical Association.

DR. WELTON: Mr. Speaker, I move acceptance of this resolution.

SPEAKER CARR: Thank you, Dr. Welton. You have heard the resolution. In the opinion of the Speaker, it would be inappropriate to refer this to a Reference Committee. I would ask your action on this resolution at this time.

All those in favor of this resolution please signify by rising.

(Whereupon the entire assemblage then stood in respectful silence for a few moments.)

I declare that it has been passed unanimously.

The floor is now open for New Business not already agendarized.

DR. WILLIAM HUFFINES [Orange County]: W. D. Huffines, a delegate from Orange County! Mr. Speaker, I rise to request permission to introduce a resolution to the House of Delegates.

SPEAKER CARR: The bylaws provide that an emergency resolution or a resolution introduced late requires a two-thirds vote of acceptance by the House before it can be accepted as the business of the House and referral to a committee.

Would you read the short title of your resolution, sir? Then we would know about what you wish to present.

DR. HUFFINES: Mr. Speaker, this is a resolution concerning the continued use of pound animals in the State of North Carolina for biomedical research and education.

SPEAKER CARR: All those in favor of accepting this as a late resolution and referral to a Reference Committee please say "aye"; all opposed "no."

[There were a couple of dissenting votes.]

It is the opinion of the Chair the "ayes" have it as more than two-thirds voted "aye" and unless there is a division of the House, it will be accepted. Is there a call for division of the House? If not, we will declare that you may introduce the resolution.

DR. HUFFINES: Thank you, Mr. Speaker.

I will read the resolved portion of this resolution.

(See Page 66, Resolution 15.)

SPEAKER CARR: You have heard the content of resolution and the resolves. It will become Resolution 15, and I'll refer this to Reference Committee II.

Is there any further New Business?

DR. J. DAVID STRATTON [Mecklenburg County]: We have a resolution that we consider enough of an emergency to introduce at this time. The resolution is really an endorsement, asking for endorsement of House Bill 74 that has to do with malpractice.

SPEAKER CARR: You have heard the intent of the resolution. It again requires a two-thirds majority vote to accept this as an emergency resolution. All those in favor of such acceptance say "aye"; opposed "no." The ayes have it. The resolution may be read.

DR. STRATTON: As a statement of why I'm reading it, the North Carolina House passed this bill yesterday and it will now go to the Senate.

This resolution says this:

(See Page 67, Resolution 16.)

SPEAKER CARR: You have heard this resolution.

This one from Mecklenburg is No. 16 and it will be referred as other matters on the same subject, to Reference Committee I.

Is there any other New Business?

If there is no other New Business I declare this meeting adjourned.

[The meeting adjourned at four-six o'clock.]

Abridge Minutes of the Meetings of the House of Delegates

SECOND SESSION

SATURDAY AFTERNOON SESSION

May 3, 1975

The Second Meeting of the House of Delegates at the 121st Annual Meeting of the North Carolina Medical Society convened at two-six o'clock.

DR. JACK HUGHES [First Vice President of the Medical Society]: Will the delegates please take their seats? I now declare the second session of the House of Delegates of the North Carolina Medical Society in session.

I will turn the program over to our able Speaker, Dr. Chalmers Carr.

SPEAKER CARR: Thank you, Dr. Hughes, for following up the procedure in the absence of our President who is with Dr. Todd at the ladies' luncheon and we expect them momentarily, but at their request we're going ahead with our business and we will interrupt at whatever proper time there is, for Dr. Todd's talk to us.

The Speaker has the unpleasant duty of advising you I made a rather grievous error Wednesday and I'm going to put it before you and let you make a decision.

The Constitution and Bylaws, and parliamentary procedure clearly require that in an election such as we had for members of the Board of Directors of Blue Cross and Blue Shield that the electee must be elected by a majority vote.

The chief teller asked me if I wanted the statement of numbers that voted and numbers voted for each candidate and I, being under the impression that only a plurality was involved, asked simply for the winners.

It does clearly state—and I'm positively correct this time—that there has to be a majority. If you don't get a majority on the first ballot, you keep on voting until you get a majority.

If one man gets a majority then he gets elected then there would be the two more and we would vote again and the one with the majority which is 51 per cent of the total would be elected.

So, I have no alternative but to request that we consider the matter in a new light and that we re-ballot.

If there is anyone who has any idea of any other disposition we can legally make I will be glad to entertain it for discussion, but if not, I'm going to ask the tellers to assemble and pass out the ballots and go through the same procedure.

This would require a majority of those voting, which is 51 per cent of those voting.

In the meantime, Dr. Payne, do we have a quorum to make it legal?

DR. PAYNE: Mr. Speaker, we have 212 delegates registered. 116 are seated in the House at the present time. 116 of the total 212 represents a majority.

SPEAKER CARR: 116 would represent a majority.

The nominees are Dr. Fleming Fuller, Dr. Alfred Hamilton and Dr. Ted Blount.

So far as I know, I should say that we are reverted exactly to where we were before the balloting began the other day.

(Several statements followed from the floor in behalf of the capabilities of the candidates.)

SPEAKER CARR: I see no one else who wishes to

speak so I suggest the tellers collect the ballots.

[Whereupon there followed distribution and collection of ballots.]

Since Dr. Todd has not yet put in an appearance, and while they are collecting the ballots, I'm going to ask Reference Committee I to please come forward and take the three chairs just in front of the lectern.

[Whereupon members of Reference Committee I then came and took their positions in front of the room.]

I have been asked why we don't go ahead while we are waiting for Dr. Robertson to make his report and my answer to that is there are eight people involved in counting these ballots. They are delegates too and I don't think we ought to exclude them from the proceedings and if we do have to have a recount, why, then that's going to require another ballot, so I'm just waiting a few minutes, hoping they can give us a report.

I don't think we ought to take eight constituted delegates and give them a job which takes them out of the meeting and deprive them of the report of the Reference Committee.

[There followed a pause in the proceedings, awaiting the tellers' report.]

DR. ROBERTSON: Mr. Chairman, we had 160 ballots; we had 114 for Dr. Fuller; 100 for Dr. Blount; and 97 for Dr. Hamilton.

DR. SHAFFNER: How many total ballots did you have?

DR. ROBERTSON: 160.

We had a lot of ballots with things crossed out.

SPEAKER CARR: Mr. Parliamentarian, will you step to my aid, please?

[There followed a brief conference between the Speaker and Parliamentarian.]

The Chair will rule that inasmuch as all three had a majority that we would leave it to the House. We have two alternatives, they are obvious. You can vote again or you can offer a motion that we select the top two.

DR. LENOX D. BAKER: So moved.

[The motion was duly seconded from the floor.]

SPEAKER CARR: It has been moved and seconded that we select the top two. Is there any further discussion? If not, I'll call for the question. All those in favor of electing—this is now the election of the two top names, Dr. Fuller and Dr. Blount, please say "aye"; opposed "no."

[There were a couple of dissenting votes.]

I declare that the "ayes" have it and these two are duly elected.

DR. SOHMER: I should like to move that the House of Delegates express to Dr. Hamilton and Dr. Stevens the appreciation of this House for their many years of excellent service in representing the Medical Society on the Blue Cross and Blue Shield Board.

SPEAKER CARR: Such a motion as a point of personal privilege is in order. It requires no second.

All in favor say "aye"; opposed "no." The "ayes" have it.

REFERENCE COMMITTEE I

We will now proceed with the report of Reference Committee I.

A few points that we reiterate every year. They seem to confuse us as much as they do you. They are set down in your little white book and they follow the standard procedure of the American Medical Association House of Delegates and that is the business before the House is the resolutions as they were introduced. They do not require additional motions as they have already been accepted.

The report of the Reference Committee, in essence, comprises part of the discussion. The question will be put on the original resolution, unless amended or unless suggested amendments are substituted by amendment by the Reference Committee and we will take them up in the usual order of the last amendment first and back down to the original resolution.

DR. ERNEST B. SPANGLER [Chairman, Reference Committee I]:

Committee I is composed of myself, Dr. Andrews and Dr. Horner.

REPORT P

The first order of business is Report "P" which is an expression of appreciation to Donald Brock Koonce, M.D.

Reference Committee recommends the following addition to this report and this should be following line 46:

And, furthermore, the House of Delegates instructs its delegates to the American Medical Association to prepare and introduce a similar resolution to the AMA House of Delegates. The Reference Committee recommends approval of Report "P" as amended.

SPEAKER CARR: All those in favor say "aye"; opposed "no."

Report "P" is adopted.

REPORT A

DR. SPANGLER: The next report is Report "A" subject: Annual Budget Estimates for 1975. Reference Committee recommends approval of Report "A."

SPEAKER CARR: Report "A" is before you. You have heard the recommendation of the Reference Committee upon it. I'll now put the question. Discussion on Report "A" is in order. Is there discussion? Hearing no response I'll call for a vote then. All those in favor of Report "A" please say "aye"; opposed "no." Report "A" is adopted.

Resolution 2

DR. SPANGLER: The next item is Resolution No. 2 and the subject is Cash Reserves of North Carolina Medical Society. It was introduced by Lincoln County Medical Society.

There was considerable discussion on this report and the final determination of the Reference Committee is as follows:

Reference Committee recommends that Resolution No. 2 be referred to a special committee to determine an appropriate level for the Society's cash reserve.

SPEAKER CARR: You have heard the recommendation of this committee on this resolution. This constitutes an amendment. It's open for discussion.

Microphone two!

DR. JOHN GAMBLE [Lincoln County]: Mr. Speaker, John Gamble from Lincoln!

SPEAKER CARR: Dr. Gamble!

DR. GAMBLE: Lincoln County introduced this resolution. I'm sure that Lincoln County delegation endorses the recommendation of the Reference Committee, but I do think it appropriate at this time to make just some comment about the resolution.

First, it's important to say that the introduction of the resolution did not mean to have any reflection on the stewardship of our money, or those who made the decision as to how reserves should be accumulated.

It is reported in the Transactions that the purpose of the Finance Committee to accumulate a year's reserve account based on the 1975 proposed budget with that reserve account would climb to \$160,000 based on this current year's budget, and of course in that budget there's \$100,000 figure that is an addition to that reserve fund.

Now, to update the figures in the resolution, this is the way our reserves will stand at the end of December, 1975.

\$179,772 notes receivable, this notes receivable is cash assets from the sale of the property that the Society owned out on highway seventy, so this is the way I construe it, the reserve account.

There is \$203,216 reserved for the operating account from 1974 and this year there's budgeted \$100,923 additional reserve budget in 1975 to be added to the operating reserve.

The total amount here is \$483,311 by the end of this year.

Now, I can see no reason why a shift in membership that was suggested yesterday as a purpose to continue to build up this reserve fund. I can see no reason why a shift in membership or any other unforeseen contingency should require that much money.

I personally don't see how these funds could be used for a new malpractice concept. If such were developed from payment of the Society or the State, such a plan would have to be financed through an assessment and payment structure from physicians that are then participating.

In the same sense, this money does not appear to be morally or legally available to be used to bail out the AMA as there are many physicians in the State of North Carolina and North Carolina Medical Society who have elected not to support the AMA.

This is not a statement by me or the Lincoln County Medical Society opposed to the AMA, but it's that this just seems to be a basis of opinion.

Thereby, it would appear that the time has come for a policy decision to be made to halt the accumulation of money just for the sake of accumulation.

I do respectfully endorse the decision of the Reference Committee and move that it be accepted, Mr. Chairman.

DR. CALDWELL: Caldwell of Gaston!

Ladies and gentlemen, this is a matter of the Finance Committee. We don't disapprove of the amendment being proposed. However, I would like to mention that all of this we have considered before from one end to the other and we could do it again, or some other committee could do it.

But, let me just mention a few things for which the reserve fund is established.

One is that we should be able to operate the Society in a period of adversity, such as what the AMA is now experiencing, without any special assessments to

our members and we can do it through a reserve fund.

The second is that some day we hope to enlarge the Society's headquarters and would like to have the reserve fund to make a good down payment on the new structure, perhaps in twenty years.

The next thing is that from time to time properties become available near the Society headquarters building in Raleigh for which we need parking and other facilities and during the past year some of the monies were spent for certain properties in this area.

Now, we have considered all of these things before; we still don't object to doing it again, it's your prerogative, but I just want to mention there are a number of things for which the reserve funds can be used and that it is prudent on any organization on a sound fiscal basis to be able to operate in a period of adversity without having to make assessments, go bankrupt or any other way we can get out of it.

SPEAKER CARR: Mr. President-elect, I'm still not clear whether you speak for or against this amended resolution.

DR. CALDWELL: Mr. Speaker, I do have some differences on that and actually I'm against the amended resolution.

DR. ROY S. CLEMMONS [Guilford County]: I'm Roy Clemmons from Guilford County! I had the privilege of sitting in on Reference Committee I when they had discussion about this matter and for purposes of information to the body, it should be made quite clear that first of all buildings are not cash assets, land is not cash assets, accounts receivables are not cash assets, in contradiction to Dr. Gamble who tended to lump all those things together. Cash assets are money and I think it's pretty obvious from what I heard in the Reference Committee meeting, is that we need to have a year's reserve.

I don't know that it needs a committee study, for some interminable period of time, I think that it might well be that this body could act now to authorize the Finance Committee to make sure that we maintain a year's reserve and if it's in order, Mr. Speaker, I would like to put that in the form of a substitute motion.

SPEAKER CARR: Would you please restate your amendment by substitution?

DR. CLEMMONS: I move that the North Carolina Medical Society maintain a cash reserve of one year's income in perpetuity to be overseen by the Finance Committee.

SPEAKER CARR: Is there a second to this amendment? [The motion was severally seconded from the floor.]

DR. WILLIAM L. CLARKE, Jr. [Catawba County]: I understand it's already the policy to have a year's reserve. That is the plan. Has this been passed by the House or is it just the policy of the Finance Committee?

SPEAKER CARR: Is the Chairman of the Finance Committee prepared to answer that question?

DR. CALDWELL: Mr. Speaker, the Chairman of the Finance Committee is not able to be present today. He asked that I answer any questions I could pertaining to this.

If I recall correctly, I believe this was brought to the attention and action of the House of Delegates last year and passed that we create a reserve fund in the amount of one year's budget.

And, that as it stands is the law now and what Lincoln County is proposing to do and the Reference Committee is to amend it and resurvey the situation, but I believe as it stands at the present time, if this proposal is defeated, we still have the authority to create one year's budget in reserve.

SPEAKER CARR: The Chair is going to rule that the last motion made is out of order at this time because the motion before us has to do with referring and the last suggested amendment was really, in essence, a new motion. It will be in order later.

Is there any further discussion on the original motion of the Reference Committee?

If not, I'll call for the question. All those in favor signify by saying "aye"; opposed "no." The "noes" have it and the resolution is defeated.

The resolution as amended is defeated. We're now back to the original resolution.

DR. GAMBLE: I understand now that the parliamentary position is that the Reference Committee substitute has been defeated and you're back now to the Lincoln County original resolution.

SPEAKER CARR: That's my understanding and my ruling, yes.

DR. GAMBLE: I would like to say this, Mr. Speaker, that the Lincoln County resolution was brought forward because of their questioning whether a \$500,000 reserve in 1974 and a \$650,000 reserve in 1975 and a proportionate increase in those substantial funds say by 1980, if we have a budget of a million dollars, we will be authorized to have a reserve of a million dollars and I think these are sizable sums.

I think we addressed ourselves to the fact that to be practical there was a point where a percentage of the total budgetary need was an appropriate amount and not just open-ended keeping up a reserve with an unending increase in a year to year budgetary cost.

This resolution is not introduced to be anti-Establishment or anything else, but to bring home to the House of Delegates and to ourselves that there is a responsible position where the Society will just build up monies for future anticipated expenses and that some of those anticipated expenses would be appropriately new business and new decision making at the time.

I hope that the Lincoln County Medical Society resolution will be adopted because we did think in our meeting that a 25 to 33 per cent reserve fund was probably adequate to meet any real needs that the Society would encounter on a year to year operational basis.

SPEAKER CARR: All right, discussion of the main motion which is Resolution No. 2.

DR. CLEMMONS: I rise to speak in discussion of the main motion. If you will recall, the Lincoln County resolution limited the reserves to 25 per cent of the annual income and I would like to speak against that.

If it's in order I would like to reintroduce the substitute motion.

SPEAKER CARR: That is now in order.

DR. CLEMMONS: To keep our cash reserves at a one year income level no matter what the constituency of the Society might be in terms of membership.

SPEAKER CARR: Would you please restate your motion.

DR. CLEMMONS: I move that this — whether it's a substitute motion, or an amended motion, or an amendment to the substitute, I don't know — but I

move that this Society maintain a cash reserve equivalent to its previous year's income.

SPEAKER CARR: Is there a second to this?

DR. BAKER: Second.

SPEAKER CARR: Is there any further discussion? If not, I'll put the question. All in favor of this — I call it an amendment to the original resolution, please say "aye"; all opposed "no."

The "ayes" have it in the opinion of the Chair. The motion carries and the original resolution need not be considered.

Dr. Reynolds and Dr. Todd, are now here.

Will you come forward please?

[Whereupon as President Reynolds escorted AMA President Todd to the podium, he was accorded a standing ovation.]

Gentlemen, without further ado, it is my pleasant privilege to introduce to you the current President of The American Medical Association, Dr. Malcolm, or Mac, Todd. He's a practicing physician in Long Beach, California.

His curriculum vitae, or a very small part thereof, is printed in your program that you have received and I'm sure that Dr. Reynolds will have a more lengthy introduction to make tomorrow morning when Dr. Todd addresses the General Session than I need make this afternoon.

So, I shall simply say to Dr. Todd that we welcome him, we thank him for his time and we know that he has something of extreme interest to say to us.

DR. MALCOLM C. TODD: (President, American Medical Association.)

(Dr. Todd's informal remarks will be submitted to the *North Carolina Medical Journal* for possible publication. At the conclusion of his presentation President Todd was again accorded a standing ovation.)

SPEAKER CARR: I'm sure that we can all thank Dr. Todd for his informative and inspiring address and I can think of no better way of stimulating interest in our continuing support of the American Medical Association than in the evidence he has given in the one or two areas that he touched on alone as reason enough for asking your colleagues to join the American Medical Association.

We must press on with the business of the afternoon. We will now proceed with Dr. Spangler and Reference Committee I.

REPORT N AND RESOLUTIONS NO. 9, NO. 16 AND NO. 10

DR. SPANGLER: Our next items include Report "N"; Resolution No. 9; Resolution No. 16; and Resolution No. 10, all of these resolutions and the report having to do with professional liability insurance.

We combined together the main aspects of these without trying to burden the combined resolution with too many things because there were so many things brought out by sixteen speakers at that Reference Committee hearing.

So this is the committee's combined substitute resolution:

The North Carolina Medical Society realizes the increasing concern of its membership regarding the cost and availability of professional liability insurance and recognizes the urgent need to cope with this situation, therefore, be it,

RESOLVED, that the North Carolina Medical So-

cietly support a bill that would create a Legislative Study Commission to study the professional liability insurance problem in North Carolina [And there has been a bill introduced, House Bill 567]; and be it, further,

RESOLVED, that the North Carolina Medical Society should continue to support the concept of professional liability reinsurance exchange as encompassed in House Bill 74, and, that in the event of an emergency, the Executive Council be empowered to act in the best interest of the membership to assure continuing liability insurance coverage for the medical profession.

And, to this end, we suggest that the Society seek the advice and cooperation of the North Carolina Bar Association.

The Reference Committee recommends the approval of the combined substitute resolution.

SPEAKER CARR: The combined substitute resolution is before you for discussion.

DR. EDWARD WHITESIDES [Section on Orthopaedics]: I thought the Reference Committee did exactly what the executive committee of the Orthopaedic Section suggested and that is we not get hung up on specifics, but that specific ceilings and amounts of money and so forth and so on, but we have a few suggestions to make concerning this resolution and the first one is that due to the climate in the country, that is the news media is presenting the facts about malpractice to the people quite well, we think; due to the fact that other states are enacting legislation now and due to the fact that it was brought out to the Reference Committee that next week we could expect someone to bring a bill to our legislature which is very similar to the Indiana legislation, that it would be highly in order for this body to approve of in advance some legislation, or approval of the idea of pursuing legislation now.

In light of that, I would like to amend this motion.

After the first paragraph, before the first "Be it resolved . . .", I would like to, on behalf of the Orthopaedic Section, state:

WHEREAS, only action by the North Carolina Legislature will change the current malpractice climate in North Carolina, and,

WHEREAS, other states, namely Indiana and Idaho have already passed such legislation, be it,

RESOLVED,—and here it should be in place of the last paragraph. I think it's all right to approach the North Carolina Bar Association, but what I'm really talking about is remedial legislation and the Bar Association doesn't legislate; members of it do.

Instead of that last paragraph, or after it, either one—we wouldn't be picky about that—

Be it,

RESOLVED, that the North Carolina Medical Society direct its officers and appropriate committees to actively seek specific legislative relief now to improve the malpractice climate in the State of North Carolina

SPEAKER CARR: Is there a second to this amendment?

[The motion was severally seconded from the floor.] Is there further discussion on the amendment?

If not, we'll vote on the substitute motion of Dr. Whitesides which actually is amendment by substitution of certain lines which he read to you.

All in favor say "aye"; all opposed "no." The "ayes" have it and the motion passes.

DR. SPANGLER: The next item is Resolution No.

1, subject of Reference Committees from the Edgecombe-Nash County Medical Society.

The Reference Committee recommends that this resolution not be approved.

SPEAKER CARR: You have heard the recommendation of the Reference Committee on Resolution No. I.

DR. LLOYD BAILEY [Edgecombe-Nash County]: I feel somewhat apologetic to speak for the resolution and I say apologetically because obviously any discussion in an open meeting like this prolongs the session and all of us want to expedite the business of the Society and get out and this is one of the reasons why this resolution is presented.

The resolutions on other matters have already been heard by Reference Committees and they have arrived at decisions and are now presenting them to us so why should there be any further discussion?

The point is that we are here as representatives of our county societies at home and we are here to represent the other members of the Society, to debate the issue, to learn from each other and to inform each other and if we are not here to do that, then we sent the wrong man here.

We are here to see that these resolutions which were passed and discussed in respective societies, in order that the matters be submitted to the House of Delegates, not to a committee. The matters at hand were felt to be important enough by the respective societies that they be heard by the full House of Delegates.

The intent of this resolution I assure you is constructive but I would like to make another point here that I think needs to be made very strongly.

This is not in any way an attack upon the members of Reference Committees. It is a wonder to me how you get anyone to serve on Reference Committees.

These men have done yeoman's work. They're working long, hard hours while some of us are out enjoying the time in more pleasureable ways and I think we're all indebted to Dr. Spangler and to Dr. Bond and others of their committees for the work that they have done.

I would like to point out what appears to be three main weaknesses of Reference Committees.

Number one, I think the most obvious is, that participation in the affairs of the Medical Society are definitely limited by having the Reference Committee system.

I think all of you who have been to Reference Committees are well aware of the fact that first of all there is a small percentage of delegates there to hear the debate and discussion of issues and this is by far the most important thing we are here for as delegates.

Then, the other matter that should be pointed out that as members of Reference Committees, the members are certainly human and when one speaker, for example, might appear before a Reference Committee to stand up for an issue or take the other side of the issue, let's say, or the person isn't such a good speaker, and then on the other side there are five or ten influential, well known, eloquent speakers who think the opposite position, well that's bound to have an effect on the findings and the report of the Reference Committee.

All of this has taken place not in the presence of the entire House of Delegates and then when we come here to vote on the issues that are presented to us by the Reference Committees, we haven't heard all of the discussion that went on the previous day.

The other matter is that when the Reference Com-

mittee appears before the House of Delegates there is some weight of authority, whether real or simulated, when a Reference Committee reports its findings. These men have obviously taken time and listened to debate and so when they stand before us and give a recommendation it's only natural for us to assume that they have put a great deal of thought into it and they have, but still we as delegates whose responsibility it is to represent our members at home, we have not heard all the debate that we should have heard.

Some of the statements have come back to us that we should have the old system we had before and there are many reasons for that and I'm sure that you have heard many of these reasons. All of us have probably heard stories about meetings that went on until midnight, and there was lots of fussing and fighting and so on.

We don't have to return to that system. The system which this resolution would appropriately bring about is to return to a system of open debate and instead of taking one day for Reference Committees to meet, we could have two days of open session where these matters could be handled half the one day and the other half the next day.

Business of the Medical Society is becoming more important day by day. The actions of the Society are reaching closer into our private lives and into our practices and obviously it's going to take more time to handle the business of the Society.

We should be willing to devote that time and what we're advocating isn't foolproof by any means. We can always, after trying it a year or two, go back and re-institute the Reference Committee system.

At least I think it's worthy of trying. It will increase participation and interest in the affairs of the Medical Society.

This is not something new. There is a precedent for it. The executive committee of the Louisiana State Medical Society took it upon itself to dissolve the Reference Committee system and to institute open sessions and debate anything that came up before the House that way.

Dr. Michael Smith, President of the Society, informed me that they have found it to be very successful. It may have prolonged the meeting somewhat but there was a great deal more interest and participation.

I respectfully request that all of you think about these things and support the resolution.

DR. LEON ROBERTSON [Edgecombe-Nash County]: This came up in our Society because several of our delegates were reluctant to come back as delegates again because they felt because of these Reference Committees, they weren't getting across their message to the full House and that it was voted on in our Society and was carried unanimously.

DR. GERARD MARDER [Section on Pediatrics]: Gerard Marder, representing the Section on Pediatrics!

I support the Recommendation of the Reference Committee about this.

We have the example just today where there were at least six or seven resolutions from various counties about professional liability.

Last year we must have had about half a dozen bills about PSRO. How in the world are we going to have to consider minor variations of each county's resolution except by a committee in trying to get together with it.

Every county does have the privilege of not accepting

what the Reference Committee decides and they can pursue it on the open floor if they see fit and this body has many times in the past overruled the committee's recommendation as we have overruled them already once today.

So, I would like to support the continued method of Reference Committees.

SPEAKER CARR: Any further discussion on this? If not, we will call for the question and we are voting on the resolution. The Reference Committee recommends a "no" vote.

All those in favor of Resolution No. 1 please say "aye"; all opposed "no."

It is the opinion of the Chair, subject to challenge, the "noes" have it and the resolution is defeated.

There is a call for a division of the House. Will the tellers please take your positions?

The Reference Committee report is a recommendation to you. The business before you in this instance is Resolution No. 1. The Reference Committee recommended a no vote which would defeat Resolution No. 1 and a yes vote or an "aye" vote would support the Resolution. There's no substitute resolution in this instance from the Reference Committee. It was a recommendation.

Will all in favor of the resolution please stand!

Will all opposed to the resolution please stand!

The resolution is defeated, without further counting if that's agreeable.

REPORT R

DR. SPANGLER: The next item of business is Report "R."

The report originally had the subject as Physician Participation in the Medicaid Program. Reference Committee I recommends that we change the report as follows:

Change the subject to read: Physician Participation in the Care of Indigent Patients and to change the body of the report starting after the words, "as follows,"

The Executive Council recommends that the House of Delegates take official action to urge and request all physicians to continue to participate in the care of indigent patients.

The Reference Committee recommends approval of Report "R" as amended.

SPEAKER CARR: Reference Committee recommends approval of Report "R" as amended. This is now before you for discussion.

DR. BEDDINGFIELD: This is merely a semantic change perhaps but the Executive Council recommendation is before us already. I question whether or not this body changes the words of Executive Council.

This House of Delegates speaks for the Medical Society, therefore for the sake of clarity I move that the amended resolution as approved by the Reference Committee read:

The North Carolina Medical Society urges and requests all physicians to continue to participate in the care of indigent patients.

Because I don't think we can change the wording of the Executive Council.

DR. SOHMER: [Forsyth County]

If I may, I should like to offer a substitute motion, to offer the original Report "R" from the Executive Council as follows:

That the Executive Council requests the House of Delegates to take official action urging and requesting that all physicians participate in the North Carolina Medicaid Program.

SPEAKER CARR: Is there a second to Dr. Sohmer's substitute motion or amendment by substitution? [The motion was duly seconded from the floor.]

Any discussion of his substitute motion?

DR. SOHMER: I know I speak for this House of Delegates and obviously the recommendation of the Reference Committee is perfectly in order.

I don't think there's any question about our feeling about continuing to care for indigent patients. Obviously we're not going to vote here today not to participate in the care of indigent patients and we're not voting against the flag, and motherhood, and apple pie and the rest of it, but the original intent of this report of the Executive Council was to urge this House to support and carry back to your component medical societies broad participation by all physicians in North Carolina in the Medicaid Program.

As you may or may not be aware of, some of you have heard me speak on this subject recently, the North Carolina Peer Review Foundation has this week contracted with HAS at the direction of the Board of Directors of the Foundation and for the first time physicians in this state have an opportunity to run the Medicaid Program and we've got a golden opportunity here that's unique in this nation, it's the only one of its kind, it's going to be the responsibility of the Medical Peer Review Foundation to determine the quality module of the program, to determine the appropriateness of the service and this program is only going to work if we all participate in this program.

It's of interest that of the claims submitted last year by physicians in this state that over 70 per cent of the patients were cared for by 550 physicians and I think this atrocious and the program can only improve if we get all of the physicians involved in the program and this is the intent of the original motion:

That the Executive Council requests the House of Delegates take official action urging and requesting that all physicians participate in the North Carolina Medicaid Program.

SPEAKER CARR: Dr. Sohmer, on due reflection, I'll rule your motion out of order as that is the original report that was sent to the Reference Committee for consideration which they have now made.

The point is and I'm subject to challenge that if you vote down the amendment you go back to the original motion anyway, which is Dr. Sohmer's motion.

DR. DAVID JOHNSTON [Mecklenburg County]: I should like to support the Reference Committee changes in this report for the following reasons:

We all have the responsibility to the public and our profession to take care of our medically indigent, but do we have or should we as a Society ask our members to accept Medicare assignments, for example, or to accept a payment by Aetna for example, or to accept a fee from Medicaid in which we have no determination with the patient?

I think it is one thing to talk about treating the medically indigent, but it's something else entirely different to start formulating and having us accept certain schemes or plans whether good or bad in terms of the medical payment for this service.

DR. CLEMONS: Mr. Speaker, I speak in favor of the amendment as stated by the Reference Committee.

I think it's quite clear that the remark that Dr. Sohmer made should be taken into consideration at such time as an organization is really viable and actually operating

and I think if it comes about in such a fashion that we will all naturally support what happens with Medicaid and other physicians, if it is run by physicians.

At the present time, I don't feel that I can support it for I know it to be discriminatory and arbitrary and I just feel that the fee involved from the strictly economical point of view would not really cover the clerical work that is involved in many cases.

SPEAKER CARR: Is there any further discussion on the issue? If not, we will vote on the amended version of the original report as introduced by Dr. Spangler. All in favor say "aye"; all opposed "no." The "ayes" have it.

The substitute motion eliminates the necessity for consideration of the original report so that item is completed and you can go ahead, Dr. Spangler.

REPORTS Q, D, H, and J

DR. SPANGLER: The next item is Report "Q" which also includes Reports "D" and "H" and the subject of this report is Proposed Changes in the Constitution and Bylaws.

Dr. Shaffner who is Chairman of the Committee on Constitution and Bylaws submitted the report.

The Reference Committee recommends approval of items one, two and three, as corrected, and item four.

Attention is called to item five which indicates that no Constitution and Bylaws change is necessary should Jones County transfer to the Craven-Pamlico County Medical Society, referred to in Report "J," and I think, Mr. Speaker, the items will be read by the Chairman of the Committee on Constitution and Bylaws on an item for item basis.

SPEAKER CARR: Because of the complexity I have asked, with the agreement of Dr. Spangler, that the Chairman of the Committee on Constitution and Bylaws read each and that we divide them for purposes of voting into their several parts and vote on each as it arises.

CONSTITUTION AND BYLAWS

DR. SHAFFNER: Item one, proposed change in the Constitution:

Amend—and I'm reading from Report "Q"—Article IV Section 6 (page 4) of the Constitution by deleting the word "student" in the last sentence and inserting in lieu thereof the word "active." The sentence will then read:

They shall have the same rights and privileges as active members. Mr. Speaker, this is a proposed change in the Constitution, if accepted by a majority vote this year would lay on the table until next year for final action.

SPEAKER CARR: Is there any discussion or questions of the Chairman of the Committee on Constitution and Bylaws?

Do I hear a motion that we accept this for business and final determination next year?

[The motion was severally made and seconded from the floor.]

I've already called for discussion and there was none, so I'll call for the question. All those in favor say "aye"; opposed "no." The motion carries.

DR. SHAFFNER: Item two, with reference to the bylaw change for the Committee on Arrangements.

Amend Bylaw Chapter X, Section 6, (page 37) by adding the underlined words so that the section will read:

Section 6. The Committee on Arrangements shall consist of three or more members. It shall arrange suitable accommodations as the meeting places of the Society, the House of Delegates and respective committees and sections, and shall have general charge of planning programs for the general sessions and of all arrangements of facilities for the holding of the annual meeting . . . etcetera.

SPEAKER CARR: That's the second reading and you may pass it this afternoon. Is there any discussion? If not, all in favor say "aye"; opposed "no." The bylaw change is adopted.

DR. SHAFFNER: Item three, Committee on Blue Shield.

It's on corrected page two.

Amend Bylaw Chapter X, Section 14 (page 49) by deleting the first six sentences and substituting therefor the following:

A Committee on Blue Shield consisting of at least one member representing each major practice specialty shall be appointed by the President for one year terms subject to reappointment, except that no member may serve more than five terms in any eight year period. The President shall seek recommendations for membership from the specialty sections and shall endeavor to ensure as full a geographic and specialty representation as practical for proper functioning of the committee.

SPEAKER CARR: This is also the second reading and can be adopted this afternoon. Is there any further discussion or questions? If not, all those in favor of this bylaw amendment please say "aye"; opposed "no." The bylaw amendment is adopted.

DR. SHAFFNER: Item four, Committee on Medical Education. This just changes the term of office.

Amend Bylaw Chapter X, Section 19 (page 53) by changing one sentence to read as follows and deleting two sentences.

The one sentence is:

Appointments shall be made for a term of one year subject to reappointment.

And, there shall be deleted:

No one shall serve for more than one five year term. When a vacancy occurs, a successor shall be appointed for the remainder of that term.

SPEAKER CARR: This also is a second reading and the bylaw is ready for your action, or any questions or discussion? If not, all those in favor of this say "aye"; opposed "no." The "ayes" have it and the bylaw change is adopted.

DR. SHAFFNER: Mr. Speaker, the Reference Committee did agree that there was no change needed in the Constitution and Bylaws to transfer Jones County to Craven-Pamlico. However, the original Report "J" just referred that to a committee.

Our committee got it and I think it's up to the House to approve this transfer of Jones County to be joined with the Craven-Pamlico County Medical Society to become the Craven-Pamlico-Jones County Medical Society. I think it would be in order, Mr. Speaker, to take a vote of approval of the House of this change.

DR. RACHEL D. DAVIS [Jones County]: Mr. Speaker, it has long been the privilege of the Lenoir-Jones and Greene counties to practice medicine together and have a coordinated society.

There has been a geographical shift of population in Jones County which has put a great part of the population closer to Craven County and it is with regret

that we see Jones County become a part of Craven, not because of any animosity or any feeling of any differences. There never have been and never will be. We're too much like the same people.

But we want the people of Jones County to know that we regret this move, we see why it shall be and if they ever want to come back to us, we open our arms wide and we'll warmly receive them. So whatever this House does, it is done with Lenoir and Green Counties' approval.

DR. SHAFFNER: Mr. Speaker, to clarify this, I move that this House approve the joining of Jones County with Craven-Pamlico County Medical Society to become the Craven-Pamlico-Jones County Medical Society.

PRESIDENT REYNOLDS: Second the motion.

SPEAKER CARR: It has been moved and seconded. Is there any further discussion?

If not, we'll vote. All those in favor say "aye"; opposed "no." The "ayes" have it and the motion is carried and the merger is effective.

REPORT F

DR. SPANGLER: The next item is Report "F," subject: Report an M.D. for Suspected Drug Abuse to the North Carolina Board of Medical Examiners.

The Reference Committee recommends approval of this report in full.

SPEAKER CARR: Report "F" is before you for consideration and the recommendation of the Reference Committee is that it be approved in full. Is there any further discussion? If not, all those in favor of this say "aye"; opposed "no." The "ayes" have it and Report "F" is adopted.

REPORT K

DR. SPANGLER: The item on your sheet is Report "J" and that has been taken care of so we'll go on to page four to Report "K," subject: Suggested Public Relations Policy Statement.

The Reference Committee recommends approval of Report "K."

SPEAKER CARR: Report "K" is quite lengthy and unless I hear objection, we will not have them read a detailed report as you have had it for some time. You have heard the recommendation of the Reference Committee on Report "K." Is there any further discussion on Report "K"? If not, I'll call for the vote.

All those in favor of adopting this report say "aye"; opposed "no." The "ayes" have it and the report is adopted.

RESOLUTION NO. 12

DR. SPANGLER: The next item is Resolution No. 12 subject: Continuing Medical Education, introduced by the Committee on Medical Education.

The Reference Committee recommends approval of Resolution No. 12.

SPEAKER CARR: Resolution No. 12 is before you recommending approval. Reference Committee recommends approval. Is there any discussion of this resolution?

If not, all those in favor of the resolution say "aye"; opposed "no." The "ayes" have it and the resolution is adopted.

REPORT O

DR. SPANGLER: Next is Report "O," subject: Report of the Committee on Medical Education, requested

by the May 1974 House of Delegates (Report "H"—1974), The Reference Committee recommends approval of Report "O."

SPEAKER CARR: Any discussion of Report "O" and the recommendation of the Reference Committee? The business is Report "O."

All those in favor of Report "O" will please say "aye"; opposed "no." The "ayes" have it and Report "O" is adopted.

RESOLUTION NO. 13

DR. SPANGLER: The next is Resolution No. 13, subject: Chemical Screening Tests by Local or Area Health Departments from the Beaufort - Hyde - Martin-Washington-Tyrrell Counties Medical Society.

The Reference Committee recommends approval of Resolution No. 13, but we would like to indicate that the cause of this being introduced was not, to our knowledge, tests being done by the health department but tests that were done under a subcontract by Region "R" personnel and Dr. Koomen indicated that the health departments were not really responsible for any lack of cooperation and I think it was clearly brought out that the health departments throughout the state cooperate fully and almost one hundred per cent with all the local county societies. We recommend approval of Resolution No. 13.

SPEAKER CARR: You have heard the remarks, the report and explanatory remarks by Dr. Spangler. This is now open for discussion.

DR. ERNEST W. FURGUSON [Washington County]: I just wanted to reiterate what has just been said. It would imply in the resolution perhaps that the health department was directly involved in this and I have learned even though the procedures emanated out of the health department, Dr. Koomen was not cognizant of the procedures and these requests did not go before the duly designated group, namely the five county medical society, prior to this and the five county medical society voted unanimously in opposition to these screening tests and I would like to make that one correction.

SPEAKER CARR: Is there any further discussion? You have heard the report of the Reference Committee, on Resolution No. 13.

All those in favor of Resolution No. 13 please say "aye"; opposed "no." Resolution No. 13 is adopted.

RESOLUTION NO. 3

DR. SPANGLER: Resolution No. 3 submitted by the Forsyth County Medical Society, subject: Establishment of a Section on Emergency Medicine.

Editorial corrections include on lines 15 and 16 the fact that the section on emergency medicine of the AMA has provisional status only and also a further correction in lines 16 and 17 to substitute the word "Association" for "Society" so that the names read: "American Medical Association" and "Southern Medical Association."

There was quite a bit of comment on this. The people that were there by a show of hands mostly favored adoption of this resolution.

The committee in its due deliberation thought it might be wise to wait until a section has been approved by the American Medical Association before we created a section within our own State Society.

Therefore, the Reference Committee recommends the House of Delegates instruct the Executive Council

to approve the formation of a Section on Emergency Medicine when such a section is granted formal approval by the American Medical Association.

SPEAKER CARR: You have heard the recommendation of the Reference Committee on this resolution. Is there any discussion?

Podgorny, Forsyth County!

DR. GEORGE POGORNY: Mr. Speaker, I would like to take a minute or two to make a few comments in this regard.

The main reasons that a group of physicians, including myself, came forth with this request are as follows:

One reason being the need for recognition for this field of endeavor and the practice of medicine particularly in this state.

Two, the important question at this time in this state, there is one of the first residency programs in emergency medicine in this area of the country.

One problem in the minds of many people is the very status of emergency medicine in this area as to the recruitment of residents in this primary care specialty and we cannot obviously tell them at this time that our medical peers in this state are looking at us in any manner or form as an organized group who practice a specific type of medicine.

Question two, the same element is a problem when you're trying to recruit emergency physicians in this state. You will hear tomorrow from Mr. Henderson in regard to the plan of access to health care, a very unusual and unique undertaking in this state by a consortium of three charitable foundations that will provide some financial help for hospitals to attract emergency physicians for an area of critical lack of medical care, that of the episodic care particularly in the smaller communities that do lack primary physicians.

Again, we are trying to attract physicians to this area. They now are sophisticated enough that one question that they have is what is the status of emergency medicine in your state.

New York, California, Michigan and Florida have established Sections on Emergency Medicine. They recognize it is a unique specialty where the practice of emergency medicine is unlike any other and goes beyond the confines of the hospital and the office and that it involves the entire community.

As you know, this state is in the forefront of emergency medical services. This involves physicians, EMP's, nurses and other personnel. It is the rightful place of the physician in this area.

He is the leader. He is the one who determines what the EMP does in the field, what kind of injections can be administered, all these areas should be within the realm of a Society like this to take the leadership.

This Society then should be to this group of primary physicians the responsibility of providing emergency medical care and that of providing EMP's and other personnel with proper direction.

For these various reasons, plus the availability of federal funds for EMS which obviously will be channeled in those areas where there is a definite leadership that can not only stand on its own feet but is also recognized by its peers. That is the importance of what we are doing.

Once the AMA approves, which we feel is a definite thing, provisional status is permanent—the reason we are provisional is that in the rules of the AMA the first two years any section must be provisional. At

the end of the two years which is the 17th of June this year a judgement will be made but not reported until the meeting of AMA in Hawaii in November.

Now, I personally am in a corner here. I appreciate the position that the Reference Committee has taken in essentially passing a favorable opinion on this.

However, as we go along with their suggested or amended—if that is the term—motion this means that at best this State Medical Society will direct the Executive Council to establish such a section sometime possibly after November.

If I may, Mr. Speaker, or Mr. Parliamentarian, I would ask what would be the most proper avenue of still trying to achieve to bring about if possible the original motion that our county society proposed in that this Society could go on record if the House of Delegates wishes so to establish such a section on emergency medicine?

SPEAKER CARR: The Chair has ruled and the parliamentarian has advised, and the Chair makes the rulings that the recommendation of the Reference Committee is a substitute motion. It will be voted upon first, after due discussion here.

If it is defeated, we then vote on your original resolution. If the substitute motion passes, your original resolution fails.

DR. BAKER: Dr. Baker, delegate-at-large!

I rise for a minute on the Reference Committee. It reads now that the Reference Committee recommends the House of Delegates instructs the Executive Council to approve of the formation of a Section on Emergency Medicine when such a Section is granted formal approval by the AMA.

I say we are doing it blindly when we tell our Council to do something when we are not certain what the AMA is going to approve.

So, I rise to suggest that you delete that first word, "approve" in the second line and suggest the word "consider," "... the Executive Council to consider formation of a Section on Emergency Medicine..."

SPEAKER CARR: This is an amendment to the substitute motion. Is there any second?

The motion was duly seconded from the floor.

Is there any discussion? Please limit it to this substitute motion now, the change of words.

If not, all in favor of this amendment to the substitute motion of the Reference Committee, please say "aye"; opposed "no." It is my opinion that the "ayes" have it and we will rule as such and that word change will be made.

DR. GEORGE T. WOLFF (Guilford County): The AMA House of Delegates asked the Coordinating Council on Medical Education to study the formation of a section.

This group met in Chicago last November to discuss and consider the possibility of residency programs for emergency medicine.

There was a great deal of concern and fear in that the proposal being made extended far beyond the emergency room and out into the community, as expressed awhile ago.

The representatives of the American College of Surgeons, the American Society of Internal Medicine, the Society of Orthopaedic Surgeons and the American Academy of Family Physicians were very concerned about this for several reasons.

The proposed residency program is a three year program which will train the person to be an emergency doctor, but if in ten or fifteen years we have enough doctors, that eighty per cent of emergency visits, if the emergencies are no longer there, these men are not going to be trained for much else.

There's concern that this needs a great deal more study and I would urge that we wait and see what the AMA does.

DR. SHAFFNER: May I speak as Chairman of the Committee on Constitution and Bylaws, for clarification for members of the House.

If the substitute motion of the Reference Committee is passed, then the bylaw change would require two readings, the first meeting and the second meeting of the House of Delegates next year, if the section is approved by the AMA and everything goes as people seem to be anticipating and the final change in the bylaws to establish such a section would have to wait until the second meeting of the House of Delegates next year; if the Reference Committee's substitute is defeated and if the original resolution is passed this year, the first reading of the bylaw change can be made now and the second reading and passage of the bylaw change can take place at the first meeting of the House of Delegates next year. Two days difference!

SPEAKER CARR: May I ask if the bylaw change has been requested of the Committee on Constitution and Bylaws?

DR. SHAFFNER: The Committee on Constitution and Bylaws must consider the change in the bylaws. If and when a resolution is passed to establish such a section it has to go to the bylaws committee and the bylaws committee can present a recommended change after such action has been taken by the House.

SPEAKER CARR: So I take it the bylaws committee has already met and acted on this proposed change with the contingencies just presented.

DR. SHAFFNER: Yes.

DR. SPANGLER: That's item six which was deferred pending this action.

SPEAKER CARR: I just wanted to make it clear that there was in the works a bylaw change already prepared for introduction this afternoon if needed.

DR. PODGORNY: A few points of clarification for the information of the House of Delegates.

Indeed the discussions have been made and taken place and indeed there's an overlap between this specialty and many others; and indeed, there is an overlap between any two existing specialties in some area of practice of medicine.

There are at the moment 35 residencies in emergency medicine in this country. There is one at Bowman-Gray School of Medicine in this state.

The Council on Medical Education has been instructed by the House of Delegates of the AMA at the last meeting which took place in Chicago of last year to provide guidelines for certification of this program; that is, that it is an assumed *fait accompli* that these programs exist, that physicians are being trained.

I don't think there's probably any one in the audience who would object to the element of having trained physicians operating in the emergency department instead of the traditional methods of utilizing rotating staff or the house staff as the primary staff for the emergency department.

I doubt that anyone would object to this if these physicians be trained properly in that field. And, in

order to think that in the future there may be something that will happen and there will be lots of other people or lots of less sickness, is the same thing as to think that hemorrhoids will disappear and therefore there will be no need for proctologists in the future!

But, obviously, emergencies will continue in different ways. There may be an over-staffing in any specialty.

I think the point of our resolution was at the moment the thing that is of importance is that of time, that once the AMA will approve this, and I have full confidence that it will, that it will go on. I think at that time the establishment of a section will be an anticlimax.

I think the farsightedness of this Society of looking into the future and seeing what it sees will prove this important area of medicine as a section at this time.

DR. HUGHES: (Durham-Orange). I move that the motion be tabled.

SPEAKER CARR: We have a motion to table.

DR. BAKER: Second.

SPEAKER CARR: No discussion! All in favor of the motion please say "aye"; all opposed "no." The "ayes" have it in the Chair's opinion. Do you wish to challenge the opinion of the Chair? If, not the motion is tabled.

SPEAKER CARR: I would like a motion that the report of the Reference Committee I be accepted as amended, substituted and changed, with thanks!

[The motion was made and seconded from the floor.]

All in favor say "aye"; opposed "no." The motion is carried.

(The Vice-Speaker Dr. Henry J. Carr, Jr., assumed the Chair.)

VICE SPEAKER HENRY CARR: We're now ready for the report of Reference Committee II, Dr. Bond!

REFERENCE COMMITTEE II

DR. EDWARD G. BOND [Chairman, Reference Committee II]:

The other members of this committee are Dr. Oscar Sapp and Dr. David Stratton.

We feel like our meeting was well attended, the discussions were good and all were heard who wished to be heard and we will go on to the green sheets.

REPORT B

Report "B," subject: State Emergency Medical Services Program. The Reference Committee II recommends approval of Report "B."

VICE SPEAKER CARR: You have before you now Report "B," State Emergency Medical Services Program. Is there any further discussion? If there's no further discussion we are ready to vote. All in favor say "aye"; opposed "no." It is approved.

REPORT C

DR. BOND: Report "C," subject: One Hundred Percent Reimbursement of Usual, Customary and Reasonable Fees in the Medicaid Program from the Executive Council.

During discussion, it was pointed out that because of budget conditions, there will be no possibility of action this year, but it will be presented to the 1976 Legislature and from comments heard it would appear that this has a favorable, at this time, outlook.

In addition, we were reminded at the committee meeting that as has been said before increased participation by more physicians in providing Medicaid ser-

vices, it would also have an effect on increased reimbursement, that is by increasing the 75th percentile.

Furthermore, the Society is already on record as favoring one hundred per cent reimbursement of usual, customary and reasonable fees.

Reference Committee II recommends approval of Report "C."

VICE SPEAKER CARR: You now have before you Report "C," subject: One Hundred Percent Reimbursement of Usual, Customary and Reasonable Fees in the Medicaid Program. What is the pleasure—is there any discussion?

DR. SOHMER: (Forsyth County) Being guilty of overkill today, I'm going to speak on the same thing again! I'm going to talk about the Medicaid program and I want to support the Reference Committee's recommendation to approve one hundred per cent reimbursement.

I would, for your information, point out last week in its flurry in the legislature to try to reduce the budget, there was a very definite effort to reduce the reimbursement to 85 per cent. It was only with the very strong appeal and intervention of Secretary Flaherty that this was not carried forward.

I have the support of Mr. Flaherty which has been expressed prior to this time. I have the support of the independent contractor, Health Applications Systems; both of them will go with the Medical Society and our legislative group to the 1976 Legislature and attempt to get the hundred per cent reimbursement of usual, customary and reasonable fees in the Medicaid program.

I would point out to you as Dr. Bond has said the only way you're going to get the 75th percentile with anything reasonable is to use high quality, high charging doctors to become involved in this program so I appeal to you to do that.

VICE SPEAKER CARR: Any further discussion regarding Report "C"? If there's no further discussion regarding Report "C," are you ready for a vote? All those in favor say "aye"; opposed "no." The motion carried.

REPORT E

DR. BOND: Report "E," subject: Prophylactic Treatment of Tuberculosis in North Carolina. There was no opposition at the committee meeting. Reference Committee II recommends approval of Report "E."

VICE SPEAKER CARR: Is there any further discussion of Report "E"? All those in favor of Report "E" say "aye"; opposed "no." It is approved.

REPORT G

DR. BOND: Report "G," subject: Common Hazards in the Working Environments and Information on Occupational Health and Safety Items.

I would note that under item six that the program was held on occupational medicine in February, so we understand, and Reference Committee II recommends approval of Report "G," realizing that item six has been accomplished.

VICE SPEAKER CARR: Any further discussion on Report "G"? If not, all those in favor of Report "G," please signify by saying "aye"; opposed "no." It is approved.

REPORT I

DR. BOND: Report "I," subject: Acupuncture Therapy Regarded as the Practice of Medicine from the Executive Council.

The committee heard considerable discussion on this subject to the effect that it was important and I have a change in wording in the comments here—and that it was important to enforce proper control—with the emphasis on enforcement and proper control—and that there should be a method of evaluation, that is evaluation of results or as someone put it, a provision for learning from this procedure.

Reference Committee II recommends approval of Report "I."

VICE SPEAKER CARR: Is there any further discussion on Report "I," subject: Acupuncture Therapy Regarded as the Practice of Medicine? If not, all those in favor of Report "I," please say "aye"; opposed "no." It is approved.

REPORT L

DR. BOND: Report "L," subject: Proposed Amendment to the Medical Practice Act.

There was a lengthy discussion and it was felt that adequate and inherent safeguards were written into the law with regard to the prescribing of drugs under careful guidance.

There was no opposition and for information, under one of the items discussed, the twelve mile limit refers only to the dispensing of drugs. Reference Committee II recommends approval of Report "L."

VICE SPEAKER CARR: Is there any further discussion of Report "L" proposed amendment to the Medical Practice Act?

DR. JACK N. DRUMMOND [Wayne County]: Drummond of Wayne County!

I would like to know how you arrived at the figure of twelve miles, why not ten, or ten and a half, or eleven; why twelve?

DR. BOND: I think Dr. Beddingfield might speak to this.

DR. BEDDINGFIELD: (Wilson County). The reason for the twelve mile figure, is as follows. Back in the early days of the Medicaid drug program in the Department of Social Services when the provision was made for the program to pay for prescription drugs from pharmacies, it came to the attention of Social Services that there were a number of dispensing physicians across the state that were in remote areas and no other way to serve their clients except for the Medicaid program to contract with them as they would a pharmacist.

After considerable discussion, with the Medical Society, with the Pharmaceutical Association, the Department of Social Services and others, it was concluded first of all that medicine and pharmacy are indeed different professions and distinct but the needs of the patients need to be served in these remote areas, so some type of limitation had to be developed at that point as to which physicians would be approved as dispensing physicians and paid the same rates as drugstores are paid.

Out of these long deliberations, an arbitrary limit of twelve miles was established and I think in this proposed amendment to the Medical Practice Act it has simply inherited that figure.

This has to do only with the compounding and dis-

pensing of drugs, and not with the prescribing of drugs by the nurse practitioner and physicians' assistants referred to in the report.

VICE SPEAKER CARR: Thank you, Dr. Beddingfield.

Is there any further discussion?

This gentleman over here, please, first!

DR. JESSE N. McNIEL [Alamance County]: Mr. Speaker, I feel my comments are pertinent—

VICE SPEAKER CARR: Pardon me, sir, could you identify yourself?

DR. JESSE McNIEL: (Alamance County). I'm a practicing psychiatrist in Burlington. There's one issue I'd like to bring before the delegates. I'm not certain whether or not this issue specifically speaks to it, but we frequently on the psychiatric unit put patients on a one day pass or several hours pass or occasionally in mental hospitals, they would be placed on a three day pass and it's extremely helpful to us if the nurse can simply give them eight hours of medication or twelve hours of medication without this having to be dispensed by a pharmacist, simply to dispense the medications for that day or what they would receive in the hospital over a two or three day period.

I don't know whether this would be appropriate to put into this, but if it is appropriate to put in here at all, I would like this type of thing considered as an amendment.

VICE SPEAKER CARR: Dr. Beddingfield, could you possibly clarify that?

DR. BEDDINGFIELD: Yes, Mr. Speaker, in my opinion that would not be relevant for this bill. It would have far-reaching implications involving an amendment to the Pharmacy Practice Act. We have before us a possible amendment to the Medical Practice Act.

A distinction has been made in the Pharmacy Practice Act as it relates to nurse practice between the administration of a dose of a drug and the dispensing of a supply of drugs, such as has been referred to here. I think that this is an important issue. I do not think it is relevant to the subject under discussion and it would serve, I fear, to confuse the subject under discussion.

DR. McNEIL: I would withdraw my amendment and just be happy that I've been able to put it before the delegates.

DR. DRUMMOND: Drummond of Wayne County again!

In speaking to the distance from a pharmacy of twelve miles, I've had some experience of this in recent years practicing in a rural area which is 11.4 miles from the nearest pharmacy and when the question arose from the Medicaid Department of Welfare Division, they said that I could not dispense because I was 11.4 miles from the nearest clinic.

Well, then, my lawyer talked to them, they immediately decided to change their minds and allowed it to go without further question.

One thing that I think helped me is I presented a picture of one of my patients with his horsedrawn cart tied to the side of my office building and I would like to say that twelve miles in rural Wayne County is not the same thing as twelve miles in Mecklenburg County, across town in Charlotte, and I would like to request that the figure of ten miles be substituted instead of twelve!

VICE SPEAKER CARR: Dr. Drummond, are you making that in the form of an amendment to the motion?

DR. DRUMMOND: Yes.

VICE SPEAKER CARR: Is there a second to that amendment?

DR. BEDDINGFIELD: Mr. Speaker, may I speak one more time to this?

I see Dr. Drummond's point, but I might say this, that this is a draft of a bill before the Legislature, and as has been indicated the twelve mile limit refers to the compounding and dispensing of drugs by nurse practitioners and physicians' assistants.

We have reason to believe in the Committee on Legislation that any compounding and dispensing by these people, by the physician extenders, probably will not be acceptable to the pharmacists and it's very likely that prior to its actual introduction into the General assembly that any reference to compounding and dispensing and twelve miles will be deleted, so this is not the principal issue before us.

I think that we in a subsequent or later action if Dr. Drummond so desires, this House could petition Social Services to change their mileage limit from 12 to 10 or whatever, but again I don't think it relates to this issue.

VICE SPEAKER CARR: Thank you.

Dr. Drummond, did you intend this ten mile limit to be put in this amendment, or as an amendment on this report?

DR. DRUMMOND: Yes, I did. *Id like the figure ten to be substituted for the figure twelve.*

If the Legislature disallows it, that's fine with me. I have a full-time pharmacist now, but I'm thinking of other physicians in rural areas who might be in a similar position.

VICE SPEAKER CARR: Now, is there any further discussion regarding the amended motion of substituting the number of ten miles for the number of twelve miles? If not, all those in favor of the amended motion please say "aye"; opposed "no." The "ayes" have it and will be changed from twelve to ten.

Now, I would like to have a vote on the proposed amendment to the Medical Practice Act as approved or recommended approval by the Reference Committee.

Is there any further discussion on the main motion? If not, all those in favor of the main motion, please signify by saying "aye"; opposed "no." The motion is carried, and Report L is approved as amended.

REPORT M

DR. BOND: Next is Report "M," subject: Recommendations from the Committee on Traffic Safety Relating to Visual Fields for Drivers, Classified Driver's Licensing System, Budget Support for Breathalyzer Program and Patients' Driving Records. There was no opposition to this and as I said before the majority of states now have a classified drivers' licensing system which is already on-going.

The Reference Committee II recommends approval of Report "M."

VICE SPEAKER CARR: Is there any further discussion regarding Report "M"? If not, all those in favor of Report "M" please signify by saying "aye"; opposed "no." Report M is approved.

REPORTS

DR. BOND: Next is Report "S," subject: Consideration of Applications for Hospital Privileges by Licensed Podiatrists.

There was considerable discussion but no opposition. Reference Committee II recommends approval of Report "S."

VICE SPEAKER CARR: Is there any further discussion regarding Report "S"?

DR. DAMERON: (Wake County) I have just been to the orthopaedic meeting where this thing was discussed again. There are many equivocations of this. Apparently, this really doesn't change anything which now exists. The law has been changed as perhaps you all may recall after we had a session with the podiatrists about six years ago which extended their scope to everything except amputation and treatment of clubbed feet.

But they have a very heterogenous group, the podiatrists do. They have one very excellent school and the first two years in case work at Western Reserve and it is my understanding from my colleagues in Winston-Salem where they have many graduates there, these people have had no real training in surgery and when these people come into the hospital they put a tremendous onus on the community to be responsible for them and this has also occurred in some other communities such as Wilmington. There are other communities, such as Jacksonville, where they work out very well and it seems to me that this thing can be handled much better on a local basis than for us, the House of Delegates to dictate to them what they can do and on this basis, sir, I move that we table this motion.

VICE SPEAKER CARR: Is there a second?

[The motion was severally seconded from the floor.]

There is no discussion of a motion to table. All those in favor of tabling the motion, please signify by saying "aye"; opposed "no."

The Chair rules that the "ayes" have it and the motion is tabled, unless challenged.

RESOLUTION NO. 4

DR. BOND: We go on to Resolution No. 4, subject: Creating Improved Communications Between Hospital Staffs Through County and State Medical Societies. This is from the Edgecombe-Nash County Medical Society.

There was considerable discussion and with full agreement that improved communications between hospital staffs and the Medical Society headquarters would be beneficial, that is a two-way street, the committee amends Resolution No. 4 as follows:

RESOLVED, that communications be improved between hospital staffs in the State and Medical Society Headquarters.

Reference Committee II recommends approval of Resolution No. 4, as amended.

VICE SPEAKER CARR: Now, Resolution No. 4 has been amended to read: The Committee amends Resolution No. 4 as follows:

RESOLVED, that communications be improved between hospital staffs in the State and Medical Society Headquarters.

Is there any discussion regarding the amended motion? If there is no discussion, all those in favor of the amended motion please signify by saying "aye"; opposed "no." So carried.

RESOLUTION NO. 5

DR. BOND: Resolution No. 5, subject: Fiscal Versus Quality Standards from the Edgecombe-Nash County Medical Society.

Again, there was a good discussion during this meeting. We were reminded during this meeting that the criteria guidelines for care provide a signal for possible professional review, that is a mechanism of screening prior to professional review.

Reference Committee II recommends this resolution be filed.

VICE SPEAKER CARR: You have before you a new motion recommending the resolution be filed.

Is there any discussion regarding this motion? All those in favor of filing this resolution, please signify by saying "aye"; opposed "no." So carried.

RESOLUTION NO. 6

DR. BOND: Resolution No. 6, subject: Medical Audit from the Edgecombe-Nash County Medical Society.

Since the concept of medical audit to evaluate hospital admissions and hospital stay is valid in the committee's opinion, we recommend rejection of Resolution No. 6.

VICE SPEAKER CARR: I'd like to inform the House of Delegates that we will be voting on the main motion. The Reference Committee recommends a "no" vote.

Is there any further discussion regarding this motion? All those in favor of the resolution as stated please signify by saying "aye"; opposed "no."

The motion is defeated and the resolution is rejected.

RESOLUTION NO. 7

DR. BOND: Resolution No. 7, subject: Certification and Utilization Review. This is from the Edgecombe-Nash County Medical Society.

We had a long discussion. The Reference Committee did not agree with the statement that PSRO law has altered the physician's role and treatment of hospitalized patients and Reference Committee II recommends rejection of Resolution No. 7.

VICE SPEAKER CARR: For clarification, the same situation exists. The Reference Committee recommends a "no" vote.

Is there any further discussion regarding this resolution? We will be voting on the main motion, main resolution. All those in favor of the resolution, please signify by saying "aye"; opposed "no."

The "noes" have it and the resolution is defeated.

RESOLUTION NO. 8

DR. BOND: Resolution No. 8, subject: Repeal of PSRO Law from the Rutherford County Medical Society.

The committee heard considerable discussion on this matter, and we have changed the wording here a little bit, so maybe you'd better listen rather than try to read it.

Last year, the House of Delegates supported the AMA intention to have the law amended and we are informed that the proposed eighteen AMA amendments to the PSRO Law are presently in the Ways and Means Committee. The possibility of repeal of the PSRO Law now would appear to be very unlikely. A recent poll of the

members of Congress showed only 45 out of 535 members favored repeal.

Therefore, Reference Committee II recommends rejection of Resolution No. 8.

VICE SPEAKER CARR: The same situation exists regarding voting. Is there any further discussion regarding this resolution?

All those in favor of the resolution please signify by saying "aye"; opposed "no."

The "noes" have it and the resolution is defeated.

RESOLUTION NO. 11

DR. BOND: Resolution No. 11, subject: Uniform Policy of Vendor Payments Under Medicare and Medicaid Throughout the State, from the Wayne County Medical Society.

As written here, several points were raised during a lengthy discussion and the choice that we would have was that to accept this resolution would "revoke usual, customary and reasonable charge policy" that has been the policy of the Medical Society and even if we were to approve this, it would require Congressional action.

Reference Committee II recommends rejection of Resolution No. 11.

VICE SPEAKER CARR: Is there any discussion regarding Resolution No. 11?

DR. DRUMMOND: Drummond of Wayne County!

We introduced this resolution feeling that doctors throughout the state trained in the same medical schools, distributed over various parts of the state, rendering similar services to patients were entitled to equal payment regardless of where they live.

The service is the same, the education is the same, the patients are similar. To state that equal payment would revoke usual, customary and reasonable charge policy is not true. I want my usual, customary and reasonable fee.

The thing that we are objecting to is for the government of the state to say that what's usual, customary and reasonable in Wilmington is different from what usual, customary and reasonable is in Charlotte, on the basis of what some 75 per cent of physicians may charge.

We feel that a physician's usual, customary and reasonable charges should be evaluated on his personal profile not on the profile of other physicians in that one community, but using the whole state as a basis of determining usual, customary and reasonable maximums.

And, I don't see how the committee felt that using a statewide standard for payment would have anything to do with individual usual, customary and reasonable charge policy.

Could you give an explanation?

We're talking about one standard for the entire state, one maximum fee for a procedure applied all the way across the state regardless of geographic area. It has nothing to do with your usual, customary and reasonable charge policy, individually, as far as I can see.

DR. BEDDINGFIELD: (Wilson County) I hate to disagree with Jack Drummond. But, I do believe there is an ample body of statistical data that does show that prevailing in different communities across the State of North Carolina of usual, customary and reasonable charges is written into the Medicare law and this is national law.

It is part of the Medicaid regulations which have the same force and effect of law that the usual,

customary and reasonable concept—although I would be the first to agree that that concept has been corrected somewhat and we are constantly striving to change that.

But I believe the thrust of this is to ask for a fee schedule. I believe this is in diametric opposition to what has been called the Asheville resolution passed by this House of Delegates several years ago to strive for usual, customary and reasonable.

We have accepted a definition of usual, customary and reasonable and in the word "customary," this was prevailing charges in the area which took geography into consideration.

I believe this is a very serious matter. I think that if we had a statewide fee schedule from third party payors, including government Medicare and Medicaid, that we would have a reduction of fees in the high charge areas and no change in fees in the lower charge areas.

I do not think that any of our members would be served by the passage of this. It has deep implications that require considerable study. It has been considered at length in the Executive Council.

They understand it. They have not endorsed a statewide fee schedule.

If this isn't what Wayne County had in mind, and they want the whole state treated as one geographic area, it's going to require a mass of supportive statistical data to support that point of view.

I speak in favor of the Reference Committee's recommendation.

DR. IRA M. HARDY, II [Section on Neurosurgery]: I speak against the Reference Committee report. The quality of neurosurgery, we don't feel is very much different throughout the state and we don't think the fee payment should be any different.

DR. GEORGE G. GILBERT [Delegate-at-large]: Just one point of clarification for Dr. Hardy, although it doesn't apply to all the other third party carriers, my first point is there is nothing we can do about Medicare in this body. This is federal regulations.

It came up two years ago when I was on the Reference Committee and our hands are tied as far as they are concerned.

However, I would point out although they are usually considered the target or the best representatives of this inequity of fees being paid to doctors in different localities, their definition of localities is not all geographic and one thing is that locality number one with Medicare and I think this is probably true with the other specialties, is that all neurosurgeons across the state today do get equal fees because by experience through the years, by the law, this has been set on the basis of charges in equal amounts whether its in New Bern, or Ahoskie, if there's one there!

The same thing is true over the state for x-rays. That specialty is in locality number one and just last year they included my specialty, urology, so that's one point of clarification.

Another illustration that I mentioned in the Reference Committee is where I can see there are reasons for different fees in different areas go back to the risk of the individual patient in his policy and you can have two men living beside each other in the same town, with a group policy with two different companies and if one of the company employees are at greater risk than the other then the doctor gets paid more, so I want to open up all these things but I did agree with

what Ed. Beddingfield said, this would give us a statewide fee schedule and this we oppose.

DR. J. BENJAMIN WARREN [Craven County]: I support the Wayne County proposal. I feel like all the doctors no matter what their practice type is should have the same consideration as the urologist, the neurologist and the radiologist and what's good for the internal medical people and the pediatrician, it ought to hold true with the urologists and radiologists.

But you've got different groups of other physicians treated in an entirely different way. It's not uniform throughout each specialty.

And, this is what we're after is to try to get the same payment for the same services rendered no matter where you are and if we do this in North Carolina, we may be ahead of the cheaper doctors in South Carolina but they're going to be behind the doctors in California and New York so it's still going to be cheaper across the country, with this fee differentiation.

We've been trying to get this straightened out here in North Carolina and this is what we need and have been trying to work for this for two years.

I would like to go on record as favoring the main motion.

DR. RABY: (Mecklenburg County)

I rise to support the statement of Dr. Beddingfield. I think I heard right that we want the same treatment as the neurosurgeons and the urologists are getting. The fact of the matter is that they were the same to start off with.

This was a profile of charges and there was no reason to put these persons in different geographical locations.

No one sat down and said, "We want to be specially treated" but this was an accumulation of data and I strongly agree with Dr. Beddingfield that if you put in the concept of the same fee for the same service throughout the state, you will be setting a fee schedule and then you are really going to be letting a tiger in the door!

VICE SPEAKER CARR: Any further discussion?

DR. JOHN L. WOOTEN (Pitt County): Wooten, delegate from Pitt County!

The reason for the lower profile in the rural areas is not because that's what we elected to have, it is because that is what we were forced to have during the days when we got what we could with no government programs.

We are now locked into a lower fee schedule not because we thought our services were less than those in the metropolitan areas and I see no reason why the tax funded payment should not be equal in all portions of the state and I'm in favor of the Wayne County resolution.

DR. EMMA S. FINK [Avery County]: I just want to make this available to you, not as a resolution or as a motion but just as information.

I seem to be one of the 550 who does 70 per cent of the Medicaid work and it's getting a little bit rough.

We're in the top of the Appalachian mountains. I never have been able to find out who set our fee schedule, but if we manage to get five dollars per patient on Medicaid we have done quite well and that really gets very difficult after awhile.

I don't think many of you realize what the inequities

are, but some of us are right at the very bottom of the scale and there has to be some way to get it up just a little bit!

DR. F. M. CARROLL [Columbus County]: I was in the committee yesterday and there was considerable discussion on this subject and the point that I see most important of all after having discussed this in the committee yesterday, is that if this situation is allowed to stand, we are going to further and further keep the primary physician away from the rural community because he knows if he goes to Charlotte that he's going to receive a much higher fee and this is where our real problem in our state is now and we're just going to force him more and more to the large cities.

I don't feel that this is at all right that the doctors in Charlotte and some of the larger areas ought to be paid the higher fee.

DR. MARDER: (Gaston County) I resent the labeling of the Wayne County resolution as fee setting or fee schedule. It is no more of a fee schedule than what they are doing now. They are still talking about a range of fees according to customary fees, regardless, but on a statewide basis rather than a regional basis.

The fact that a pediatrician in Sylva, North Carolina who is an excellent pediatrician, submits a \$10 bill or fee rather and he is in the 75th percentile in his region is no reason at all compared perhaps to a Wake County pediatrician who submits a \$10 fee and he is in the 75th percentile of his and by having it uniform in the state that does not make it out of the "revoke usual customary and reasonable policy" so I'm in favor of the Wayne County resolution.

VICE SPEAKER CARR: If there's no further discussion, we'll take a vote by head count.

All those in favor of the motion please rise! The tellers will please count those.

DR. ROBERTSON: We have 75 for the resolution and 55 against.

VICE SPEAKER CARR: The head count reveals 75 for the resolution, 55 against the resolution. The resolution carries.

RESOLUTION NO. 14

DR. BOND: Resolution No. 14, subject: Suggested Position Paper on Patient Education from the Committee on Public Relations.

The committee would like to amend Resolution No. 14 as follows: In line 16:

RESOLVED, that patient *medical* education *experiences* be recorded in the medical record, and be it further,

RESOLVED, that the provision of appropriate patient *medical* education should be included as an integral component of physicians' services.

Just the addition of those words which we think strengthens it. Reference Committee II recommends approval of Resolution No. 14, as amended.

VICE SPEAKER CARR: Is there further discussion on the amended resolution by the Reference Committee?

If there's no further discussion, we are ready to vote. All those in favor of the amended resolution by the Reference Committee, please signify by saying "aye"; opposed "no." So carried.

RESOLUTION NO. 15

DR. BOND: Resolution No. 15, subject: Use of Pound Animals in Biomedical Research and Education

from the Durham-Orange County Medical Society.

Reference Committee II recommends approval of Resolution No. 15.

VICE SPEAKER CARR: Is there any further discussion on Resolution No. 15? All those in favor of Resolution No. 15, please say "aye"; opposed "no." So carried.

PRESIDENT REYNOLDS: Mr. Speaker, I feel that the House of Delegates should have some information on the background of Report "S" that they should know and I would like to move you to resume consideration of Report "S."

VICE SPEAKER CARR: Report "S" can be reconsidered or discussion can be resumed on Report "S." The motion has been made and is there a second?

DR. HUGHES: Second.

VICE SPEAKER CARR: This motion on this report is not debatable. A majority will get this back on to the floor again.

Report "S," the subject is Consideration of Application for Hospital Privileges by Licensed Podiatrists.

This report was tabled earlier. By Dr. Dameron's motion. Now, we have a motion to reconsider or resume consideration on this motion, to take it off the table and debate more and maybe take further final action on it.

All those in favor of resuming consideration of Report "S," please say "aye"; opposed "no."

The "noes" have it by my count unless someone wishes to challenge it. Do you wish to challenge it?

DR. BOND: Mr. Speaker, I move that the report of Reference Committee II, as amended, be accepted.

[The motion was duly seconded from the floor.]

VICE SPEAKER CARR: Is there any further discussion about this? All those in favor please say "aye"; opposed "no." The report is accepted.

REFERENCE COMMITTEE ON PRESIDENT'S ADDRESSES

SPEAKER CARR: I now recognize Dr. Crutchfield who will make a brief report from his committee on the President's Messages to the Society.

He is speaking for the committee, by request of the Chairman, Dr. Blackwelder.

DR. CRUTCHFIELD [Chairman, Committee on President's Addresses]: Mr. Speaker, this is a report for the chairman of our Committee, Dr. Verne H. Blackwelder.

The other member of our committee is Dr. Charles M. Hicks. In view of the lateness of the hour, we want to offer this report on the President's Addresses which our committee found entirely favorable and we recommend that it be accepted without reading.

[The report of the Committee on the President's Addresses is as follows:

Mr. Chairman, members of the House of Delegates and other concerned friends:

The Committee on the President's Addresses consisting of Verne H. Blackwelder, Chairman, A. J. Crutchfield and Charles M. Hicks, have considered the two addresses of our esteemed President Frank R. Reynolds, found them to be filled with good and bad

news which requires the attention of all doctors.

He reports that PSRO which seemed to be nearly all bad has, under the able leadership of Dr. Frank Sohmer, been partially implemented and seems at this point to be less frightening than it seemed to be just one year ago.

Continuing medical education requiring completion of 150 accredited hours over a three year period is about to become fact, awaiting only final decisions with AMA and North Carolina Medical Society Committee on Medical Education concerning accrediting details. Our area is richly endowed with acceptable ways to allow completion of these hours and no hardship should be imposed upon any member by this plan.

The entire staff in State Headquarters is praised for continuing good work and we wholeheartedly add our endorsement.

Bad news begins with his report that medical liability insurance problems are under active study but far from solved.

To ensure availability of insurance for the immediate future, we agree that "claims made" type may be required but heartily endorse the intensive study plan by all concerned to permit better solution of the problem in our state by another year.

Public Law 93-641 requiring far-reaching Health Planning and Resource Development by bodies made up of more consumers than providers and directed by *one man*, the Secretary of HEW, indeed casts an ominous cloud over the practice of medicine.

National health insurance held in abeyance by our slumping economy is not dead and we agree that vigorous leadership will be needed to help shape it into a useful form for all concerned.

We agree that as individuals we may be overwhelmed by these great problems, but as members of the North Carolina Medical Society and AMA our strength can be a mighty force to protect the good in our present system and to help improve the not-so-good.

We rejoice to learn that North Carolina Medical Society members have increased beyond 4,470 but gloom quickly grips us when we look at our great problems and are told that AMA dues have been paid more slowly than in 1974. To correct this error should be our first order of business when we return home.

We commend President Reynolds upon his good work and excellent addresses and urge each member to read and reread his messages.]

SPEAKER CARR: The Chair will exercise its prerogative to accept the report without reading and refer it to the Executive Director who will see that it is placed in the proper order in the Transactions so you can read it when you later get your Transactions.

Thank you, Dr. Crutchfield, and your other committee members.

The floor is now open for New Business. Is there any New Business?

I was informed that there would be New Business. I don't want to overlook this. Is it that the cocktail time has got you, or have you lost your New Business ideas?

Hearing none, I will declare this meeting is adjourned, sine die.

(The meeting adjourned at five-forty o'clock)

General Sessions

FRIDAY MORNING SESSION

May 2, 1975

The First General Session of the 121st Annual Meeting of the North Carolina Medical Society convened at nine-five o'clock in the Cardinal Ballroom of The Pinehurst Hotel, Pinehurst, North Carolina. Dr. Frank R. Reynolds, President of the Medical Society, presiding.

PRESIDENT REYNOLDS: If everybody would take their seats, we will get started this morning, on time, since we have a very busy program.

First, I will ask the Reverend Hutchinson if he will give the invocation. He is the Methodist District Superintendent of Greensboro. He has been very active with physicians.

He serves on our Medicine and Religion Committee. He has been a great deal of help to us and it's with a great deal of pleasure to ask Reverend Hutchinson to give the invocation.

REVEREND ORION N. HUTCHINSON, JR. [District Superintendent, Methodist Church, Greensboro, North Carolina]: Let us stand for prayer!

Lord, through every day Thy love for us and Thy mercies never fail. We rejoice in the amazing truths which thou has conveyed to us and the more amazing ones yet to be discovered.

We invoke this day upon a pilgrimage of exploration to find those things, those facts, those processes that will enable us to serve others better.

We are awed by the responsibility, but thankful for the guides along the way.

So may this be a good day because thou art with us through the process of discovery and then through the processes of application and let those learn who here shall meet.

True wisdom is with reverence crowned and science walks with humble feet to seek the God that faith has found.

Amen!

PRESIDENT REYNOLDS: As most of you know, the North Carolina Medical Society has been extremely fortunate in having a very close working relationship with the medical schools in our state.

Their staffs are invaluable members of our Society, they work with our committees and they have been most gracious in the last several years to take charge of our scientific programs.

This morning, it gives me a great deal of pleasure to turn the program over, at this time, to Dean Chris Fordham of the University of North Carolina School of Medicine.

DR. CHRISTOPHER C. FORDHAM, III [Dean, University of North Carolina Medical School, Chapel Hill, N. C.]:

Thank you, Mr. President. I think the fact that the medical schools have been asked by the Society to develop a significant part of the program over the last several years is one expression of what is evident on all sides, that those of us who work full time in the medical schools and those of you who practice full time in the communities across our state have a great deal in common and that our relationships have been growing in a very constructive way for some years. I believe there

are few states which can match the kind of relationships we've had.

We're all subject to increasing bureaucracy. We're the subject of increased criticism and in the face of sterling, if imperfect efforts to serve society, and we have specific pragmatic problems of crucial significance which we share such as malpractice insurance and so on.

We have in the State of North Carolina, I think, developed a basis for a regional health educational program involving a partnership between the universities and the communities, physicians, hospitals and trustees of those hospitals through the area health education program which is second to none in its promise and what it has been able to accomplish thus far.

I would like to express my gratitude to the Society and its constituencies for the strong support we've had in the development of that program thus far.

Clearly, the program will have no meaning and no impact without a close association with the practicing physicians in communities where health education goes on.

And, clearly, there will be problems along the way, but with good spirit and good motivation, most of them can be resolved.

I might just take a moment to tell you, what I'm sure you already know, that we share a changing situation, state and nationally.

I've just returned from a meeting of medical schools, nationally, and it's very clear that medical education is in trouble, perhaps more so than at any time except maybe in the late sixties with respect to its financial basis.

Having responded vigorously to the call for more physicians and I thought I would just give you a few numbers—there were six thousand graduates in 1935; seventy-five hundred in 1965, so a very modest change in thirty years.

Then in the space of one decade, from seventy-five hundred to twelve thousand and shortly fourteen thousand. By the end of the decade, we may have as many as seventeen or eighteen thousand students per class.

There has been a substantial modification of the curricula and the programs of medical schools across the country, including our own, with increasing emphasis on primary care, family medicine, community hospital training and health care delivery.

At the same time, we have a continued key responsibility for the quality of the educational programs, for medical practitioners of the future and for the enhancement of scientific basis for the practice of medicine.

In this situation, of having expanded the programs both in terms of numbers and in terms of outlook and trying very hard to depend on scientific aspects and the need for continued biomedical research, we find ourselves faced with a real potential of declining resources and curtailment of efforts.

I think you all received a copy of a letter from Dr.

Ken Sawyer, Director of AMA-ERF, about a week ago in which he expressed deep concern about the financial problems that many medical schools expect to encounter.

The federal governments has made it clear through the administration for several years now that it expects state and local communities to take greater responsibility for the funding of medical education in both public and private medical schools.

In North Carolina, where we now have three full-fledged academic medical centers, perhaps more than any other state in the fifth quartile of per capita income, we simply can't afford to see the support of these institutions reduced when there is real and substantial momentum in addressing the issues which are of concern to all of us.

I have personally supported the concept of state assistance to our sister private schools at Bowman-Gray and Duke. These are both institutions which represent a great resource for the State of North Carolina and working closely with them and with the Society, I think a great deal has been accomplished.

I want to thank Dr. Frank Reynolds, his predecessor, Dr. Gilbert, his successor, Dr. James Davis for the opportunity for us to have close communications with the Society in both formal and informal ways.

I think together we have not failed to respond to common concerns and I look forward especially to that continuing close relationship.

Now, this morning's program from our Department of Medicine should be a very good one. I am especially proud of the Department of Medicine at the University.

Its thoroughly devoted efforts, its breadth and depth, I'm confident after travelling across the country a good deal to other medical schools, and would rank this among the best Departments of Medicine in the country.

It's a read credit to the University and the State. It's a very devoted, capable, scholarly group of faculty and I'm delighted that they have this opportunity to present the morning's program.

I'm also especially pleased at Dr. John Sessions, Professor of Medicine and one of our senior and distinguished faculty, a doctor's doctor, as it were, who will begin the program. So thank you so much.

DR. JOHN T. SESSIONS, Jr. [Professor, Department of Medicine, University of North Carolina Medical School, Chapel Hill, N. C.; Moderator.] Thank you, Dr. Reynolds, and Dr. Fordham. It is a pleasure to be here. My introductory remarks will consist of just a few items.

Dr. Oscar Sapp, as you know, is an Associate Dean and is in charge of continuing education at Chapel Hill. He played a major part in organizing this program, as you can see, by virtue of the clinical material to be presented.

The idea, I'm sure, was to try to provide something that would be of interest to everybody here, though recognizing that not everybody would be interested in all of the program.

I'd like to start the program by introducing Dr. Daniel T. Young, who is Professor of Medicine in the Division of Cardiology at Chapel Hill.

Dr. Young will speak on Rehabilitation After Myocardial Infarction.

DR. DANIEL T. YOUNG [Professor of Medicine,

Division of Cardiology, UNC Medical School]:

(Dr. Young's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. JOHN T. SESSIONS, Jr. (Professor, Department of Medicine, University of North Carolina Medical School, Chapel Hill, N. C.) We'll save a few minutes by virtue of the fact that Dr. Fordham introduced me earlier. I'd like to tell you how pleased I was to be offered the opportunity to say something to you this morning about advances in gastrointestinal endoscopy.

(Dr. Session's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR SESSIONS: The next speaker we're delighted to have with us this morning, is Dr. Janet Fischer, Professor of Medicine, Associate Professor of Bacteriology, University of North Carolina Medical School, Chapel Hill, who will speak to us on Rocky Mountain Spotted Fever.

(Dr. Fischer's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR SESSIONS: The next paper of the day is by Dr. William B. Blythe, Professor of Medicine and Chief of the Division of Nephrology at The University of North Carolina Medical School at Chapel Hill. Bill's talk will be on Chronic Dialysis and Renal Transplantation in North Carolina in 1975.

(Dr. Blythe's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SESSIONS, MODERATOR: The next presentation is by Dr. Jeffress G. Palmer, Professor of Medicine in the Division of Hematology, University of North Carolina Medical School, Chapel Hill. Dr. Palmer will speak on Leukemia and Lymphoma.

(Dr. Palmer's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR SESSIONS: The next paper, The Spectrum of Alcoholic Liver Disease, is by Dr. E. M. Bozyski, Associate Professor in the Division of Gastroenterology, University of North Carolina Medical School, Chapel Hill.

(Dr. Bozyski's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR SESSIONS: The last paper of the morning is by Dr. Nortin M. Hadler, Assistant Professor of Medicine and Bacteriology, Division of Rheumatology and Clinical Immunology, University of North Carolina School of Medicine, Chapel Hill. His paper is on The Medical Management of Rheumatoid Arthritis.

(Dr. Hadler's paper submitted to the *NORTH CAROLINA MEDICAL JOURNAL* for possible publication.)

PRESIDENT REYNOLDS: I'd like to thank Dr. Chris Fordham, Dr. Sessions, the faculty at the University of North Carolina at Chapel Hill, for a very excellent program. We certainly do appreciate it.

At this time, Dr. Harvey Estes, our hard working Secretary, has an announcement to make.

DR. E. HARVEY ESTES [Secretary of the Medical Society]: Several of you may be aware at previous meetings we have announced the results of the awards from the previous year.

We have changed this format this year because it seemed a bit anticlimactic to have someone come back a year later to get an award.

However, we did feel that you should know who won the award in the various categories from last year.

The Durham-Orange County Award went to a paper called, "The Impact of Automated Multi-Phasic Health Testing on the Future of Traditional Medical Practice." This paper was submitted by Kevin Soden who is a resident in family practice at Charlotte Memorial Hospital in Charlotte. This award will be made locally in Charlotte.

The Moore County Award was made to a paper entitled, "Pediatric Urological Roentgenology." This paper was presented before the Section on Pediatrics last year By Dr. Herman Grossman who is in the Department of Radiology and Pediatrics at Duke University Medical Center.

This certificate and medal was presented to Dr. Grossman at the Durham-Orange County Medical Society meeting on April 9, 1975.

The Wake County Award, "Urinary tract Infections in Children," was presented by Dr. William Conley,

Department of Pediatrics, UNC School of Medicine, and this too was presented at the Durham-Orange County Medical Society meeting on April 9, 1975.

We would announce that there will be awards from this year's presentations and these will be announced next year.

It has already been mentioned that the total registration, or total attendance at these meetings has been excellent. The average attendance for the morning has been about 150. We have about a three times increase in attendance.

I think it's all related to the quality of the presentations which I agree have been excellent.

Total registration for this meeting thus far was 387 physicians. This was at eleven o'clock this morning and this is by way of back-handedly advising you that those of you who have not registered should please do so.

[The meeting concluded at twelve-twenty o'clock.]

SATURDAY MORNING SESSION

May 3, 1975

The Second General Session of the 121st Annual Meeting of the North Carolina Medical Society convened at nine o'clock, Dr. Jack Hughes, First Vice President of the Medical Society, presiding.

CHAIRMAN HUGHES: In keeping with our custom, we're going to start on time and, hopefully, end on time.

I have only one announcement and that is to remind you that the coffee at the time of the ten-thirty break is supplied through the courtesy of the North Carolina Medical Assistants.

I suppose I should have officially declared the Second General Session to be in session, which I now do.

Our program this morning, the "Surgical Session," will be provided by the Department of Surgery of Duke University Medical Center in Durham and our moderator is Dr. David C. Sabiston, Jr., who is James B. Duke Professor and Chairman of the Department of Surgery at Duke University Medical Center in Durham.

DR. DAVID SABISTON, Jr. [James B. Duke Professor and Chairman, Department of Surgery, Duke University Medical Center, Durham; Moderator of the Session]:

When the plan was developed several years ago to have the various departments of the three medical schools throughout the state present portions of the program of the North Carolina Medical Society, it became traditional to have the dean of the appropriate medical school involved make some remarks at the beginning upon the progress in the school in the recent past.

It's a pleasure for me this morning to have the privilege to introduce to you Dr. Ewald W. Busse who is our Dean, actually called the Director of Medical Education, and also has the title of Adjunct Provost at the University.

Dr. Busse is a native of Missouri and a graduate of Westminster College, which incidentally gave him an honorary degree some years later. He also graduated from Washington University in St. Louis and obtained training at the Barnes Hospital.

He was retained on the faculty there in the Department of Psychiatry and then became Professor of Psychiatry at the University of Colorado.

It was from there that we were able to attract him to Duke as Chairman of the Department where, during the years, he was able to build an unusually strong Department of Psychiatry.

He has been President of the American Gerontological Society, of the American Psychiatric Association, and was recently chosen as one of the six in the medical profession throughout the United States for the President's Advisory Panel on Biomedical Research which has a great responsibility in selecting research plans and support and will make a report during the coming year.

It's a privilege to have Dr. Busse with us this morning and to discuss some recent progress at Duke.

DR. EWALD W. BUSSE [Director, Medical Education, Duke University Medical Center, Durham]:

I'm very pleased to see the courageous devoted people here at this early hour. These are the kind of people we need to support not only Duke but all of medicine.

I hope some more will appear for what I know will be a very wonderful meeting.

I'd like to briefly talk about four different facets at Duke: The medical school group, their curriculum, the house staff, the faculty and then something about the facilities.

First of all, I would like to say that the President of the Davison Society which is the student organization, Dwight Robertson, is in the audience this morning and, Dwight, I think it would be great if you just stood up so that they can see what our leadership looks like, Dwight Robertson!

I must say we have been very fortunate in the medical school group in that we've had excellent leadership and I feel that in the hands of Dwight, the organization will continue to be very effective and really be a true spokesman for the medical students and have tremendous input into all of our activity.

I think you ought to be reminded a little bit of what goes on at Duke. Some of it you've heard me say before.

But, it looks again that we will exceed four thousand applicants for the hundred and fourteen slots.

I suspect that the class coming in next September will be very similar to the current class, the current freshman class, and that means with the current class that there are twenty-six states represented or foreign countries. There are really in this group thirty-six from North Carolina. There are thirty-one women and there are nine blacks.

We try hard to have a representative socially balanced class that we hope will meet the social needs and the medical needs of the future and I do hope we will be able to continue a very sensible way of looking at this most difficult job of selecting medical students.

Now, with Dwight here, I think you ought to be aware that the medical student body has been working very hard to develop really an honor code.

They, I am sure, are aware of the drift away in some other leading colleges of the United States from an honor code and an insistence that people behave properly during their educational years.

They, in fact, have really done a remarkable job of clarifying points which were not clear and I feel very certain that it will help making certain that medical students behave in a way that we'll be proud of them and we expect them to behave when they maybe become physicians.

I have no doubt that our curriculum will continue to change. We do have our so-called Quail Roost Conference scheduled and at that conference we will have an opportunity to look at the curriculum and listen to the students and make the appropriate revisions.

Now, as far as the house staff is concerned, I think from my standpoint the most notable achievement is really the very strong family practice program that has emerged at Duke.

It has built very rapidly to 36 residents. They took in 12 this year. I wish I knew exactly the number of applicants they had. I did have it somewhere in my notes but they did have a remarkable number of applicants from very good people and they do have an exceptionally fine program and I know this will continue.

However, I also know that with the development of AHEC's in North Carolina, the house staff as well as our students are very much interested.

We have for years had outreach programs and I do feel that this particular program will strengthen this without any doubt at all and we look forward to expanding our activity and our so-called outreach programs via the AHEC group.

Now, as far as the faculty is concerned, I think you ought to know about some major things that have happened.

Many of you know Dr. Daniel Tosteson who has been the Chairman of the Department of Physiology and has been Chairman of AAMC just a year ago.

He has recently accepted the deanship at the University of Chicago. As all of you know, it's an excellent school, like all schools. None of us is an exception in this rather difficult time.

There are problems but I know Dan is an exceptionally capable leader. We are very sorry that he will be leaving Duke and yet we know the University of Chicago is very fortunate to have such a very capable person leading them.

There are other things you ought to know about the faculty just so you are aware of it.

In the fall of this year there will be a day honoring Tom Kinney. I think it will be about November 20th.

You remember that Tom Kinney occupied the position that I now occupy and has been Chairman of the Department of Pathology. He will be replaced by Dr Jennings who is currently the Chairman and Professor of Pathology at Northwestern University.

As to facilities, I think you know that there are several structures now being built on the Duke campus.

You are aware that the Seeley Mudd Library a five floor triangular building is moving along very nicely. It will be ready for occupancy sometime in early fall, but we will not have the dedication of it until April.

I do hope that all of you who are interested will have an opportunity to see this. It will be a remarkable structure. We will be able to provide good working space for at least five hundred students plus other types of activities. It will have very good audio-visual capabilities as well as the library.

You are aware that our library is an exceptionally good one and I do believe it will grow even further.

We did leave some shelf space which was worthwhile and the shelf space will help a lot because we have things like a bookstore we'd like to get in there.

Very quickly, the Jones Building is reaching completion for the comprehensive cancer center. I should take a moment and say that this comprehensive cancer center needs facilities, actually three facilities at a cost of sixteen million. One has been completed which houses the animal experimentation for hazardous agents.

The basic research building which is moving along very nicely and rapidly to completion and the clinical research building which will start construction in early fall.

The Whitehead Foundation, the institute that has seen fit to locate at Duke, is moving along too. I do not believe they will get to the drawing boards with their building until probably late spring of next year. However, they are pulling together their staff. The new hospital deserves one word of comment. You all are aware that this is an enormous undertaking, it is badly needed. We continue to have our ups and downs.

If you would ask me to give my own opinion of this, I believe from everything I've seen, that it will emerge in spite of the difficulties. The actual base money that is needed to get it off the ground is in sight and I think that's always the key, whether you have a large enough amount of money to really move along with the entire structure.

So, all in all, I think we are doing reasonably well. We have our problems like all schools, particularly with the government, but I don't think we can do an awful lot about them.

I appreciate the opportunity of talking with you and I look forward to the program today.

MODERATOR: DR. SABISTON: Our next speaker on the program is an Assistant Professor of Surgery. He is supported by a research career development award from the NIH for his research study and in addition, carries on a very active practice in cardiovascular and thoracic surgery. Dr. Robert W. Anderson is going to speak to us on the topic of Management of Shock.

(Dr. Anderson's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: Our next speaker began his interest in gastrointestinal disease, particularly the surgical aspects of it, during his residency which was taken with Drs. Ravden and Jonathan Rhodes at the University of Pennsylvania. He then was on the

faculty at the University of California with Dr. Dunphy and had the privilege of spending eighteen months working in basic physiology of the stomach with Dr. Grossman of Los Angeles.

He's going to discuss a relatively new procedure for the treatment of a common problem in medicine, namely peptic Ulcer.

Dr. R. Scott Jones will discuss Parietal Cell Vagotomy for Peptic Ulcer.

(Dr. Jones' paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: Our next speaker is going to talk on a difficult problem that everyone encounters at some time or another and this can constitute quite a dilemma. Dr. Patrick A. Kenan, Associate Professor of Otolaryngology, is going to talk on Surgical Management of Severe Epistaxis.

(Dr. Kenan's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: For a number of years, the Division of Neurosurgery at Duke under the leadership of Drs. Woodall and Odom, have had the largest number of brain tumors of any service in the country and one of the products of their residency program, that we were fortunate in being able to retain on the full time staff and who is now an Associate Professor of Surgery or Neurosurgery, has taken a special interest in one group of these tumors, a very difficult group, namely the gliomas. His work at the basic science level as well as the clinical level has been very strongly supported by the National Institutes of Health.

I'm going to ask Dr. M. Stephen Mahaley to talk to us about the Chemotherapy for Malignant Gliomas of the Brain.

(Dr. Mahaley's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: I'm confident that there is scarcely a person in this room who has not known a patient who has obtained great relief from pain and return to normal ambulation following total replacement of the hip. It has been one of the dramatic contributions of surgery in the last decade and in this area our next speaker is a pioneer.

Dr. Donald E. McCollum, Professor of Orthopaedics, and his associates have accumulated a series of some thousand patients with total hip replacements, with what are considered to be extraordinarily good results.

Dr. McCollum is going to talk to us now on Indications and Results in Total Replacement of the Hip.

(Dr. McCollum's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: Last year in this country some six hundred thousand of our citizens died as a direct result of coronary atherosclerosis and its complications and predictably a number of us in this room this morning will fall victims to it.

Our next speaker began his interest in cardiovascular surgery while a medical student; indeed his first paper as published with Dr. Michael DeBakey as a co-author. He became an intern under Dr. Blaylock in surgery at Hopkins and then went to the NIH where he served for two years under Dr. Morrow and we were fortunate in attracting him to our residency program here which he completed and is now an Associate Professor of Surgery and Director of the Surgical Aspects of Myocardial Infarction Research Unit at Duke.

Dr. H. Newland Oldham, Jr., is going to speak to us on the Current Status of Surgery for Myocardial Ischemia.

(Dr. Oldham's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: Our next speaker is well known to almost all North Carolinians. He's a graduate of the University at Chapel Hill, graduate of the Harvard Medical School, took his training in surgery under Dr. Churchill at the MGH and is going to speak to us this morning on Surgical Management of Regional Enteritis, he is Dr. William P. J. Peete.

(Dr. Peete's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: Surgery in the past several years and a variety of its disciplines has turned to microvascular techniques and our next speaker who is an Assistant Professor of Plastic and Maxillofacial Surgery and completed a program under Dr. Picrel and Dr. Georgiade is going to speak to us on Composite Flap Transfer Utilizing Microvascular Techniques: Dr. Donald Serafin.

(Dr. Serafin's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: Our next discussant is a graduate of Dr. Nathan Womack's residency training program at the University of North Carolina. He became interested in transplantation and spent several years with Dr. Bernard Amos in Immunology of transplantation and is now Associate Professor of Surgery at Duke and Co-Director of the Transplant Program and will speak to us on the Present Status of Renal Transplantation: Dr. Hilliard F. Seigler.

(Dr. Seigler's paper submitted to the *North Carolina Medical Journal* for possible publication.)

DR. SABISTON, MODERATOR: Our next speaker is an Associate Professor of Urology. He's a graduate of Harvard, took his internship and residency with us in general surgery and remained in Dr. Glenn's urology program and so Dr. John L. Weinerth will speak to us on Diagnostic Methods in Pediatric Urology.

(Dr. Weinerth's paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: Our next speaker, quite early in his surgical residency career began an interest in neoplastic disease. As a matter of fact, he took out nearly five years to work in basic tumor immunology at both the National Cancer Institute in Bethesda, and at the Carolinski Institute in Stockholm.

He's a member of the National Cancer Task Force of NIH. He's in charge of our breast clinic at Duke and will soon become Director of Clinical Research of the NIH Unit at Duke.

It's a pleasure to introduce Dr. Samuel A. Wells, Jr., Associate Professor of Surgery, who will talk on the Use of Adjuvant Therapy in Patients with Early Breast Cancer.

(Dr. Wells' paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: Our final speaker is from our Department of Anesthesiology. He is a very innovative individual who has meant a great deal to us in the operating room and it's a great pleasure to introduce Dr. David A. Davis who will speak to us on the Role of Monitoring in Modern Anesthesia.

(Dr. Davis' paper submitted to the *North Carolina Medical Journal* for possible publication.)

MODERATOR: This concludes the program from the Department of Surgery. You've heard presentations from each of our seven major divisions including an additional one from the Department of Anesthesia.

I want to thank the audience so very much on behalf of our speakers this morning, both for the size of your attendance and more especially for your undivided attention. The latter has certainly been apparent to one sitting up here at the head of the room.

CHAIRMAN HUGHES: We now come to the highlight of the second clinical session in which we will hear words of wisdom from our leader, who is known to all of you and without further ado, I'd like to intro-

duce Dr. Frank R. Reynolds, President of the North Carolina Medical Society.

(The entire assemblage according President Reynolds a standing ovation as he approached the podium.)

President Reynolds: Thank you, very much. I appreciate this opportunity to present this Annual President's Address.

(President Reynold's address entitled "The President's Farewell Address was published in the *North Carolina Medical Journal*, July 1975, Vol. 36 No. 7, page 401. Following the presentation of his address, President Reynolds was again accorded a standing ovation.)

(The meeting concluded at twelve-forty o'clock.)

SUNDAY MORNING SESSION

May 4, 1975

The Third General Session of the 121st Annual Meeting of the North Carolina Medical Society convened at 9:05 o'clock. Dr. Frank M. Sohmer, Jr., Second Vice President of the Medical Society, presiding.

CHAIRMAN SOHMER: Good morning, ladies and gentlemen. It's a pleasure to have you here. It's a pleasure for me to preside at the Third General Session of the North Carolina Medical Society's annual meeting.

I will go right ahead with the program so we can try to maintain some semblance of order. We've got a very interesting group of people with us this morning who can provide very significant information to us. I hope that you will feel free to ask questions, to respond to these individuals.

All of these people who will talk to you this morning, all of you know, and I don't think you need any introduction to them. Dr. Jake Koomen, of course all of you know, is the Director of the North Carolina Division of Health Services.

DR. JACOB KOOMEN [Director, North Carolina Division of Health Services, Department of Human Resources]: Thank you, Dr. Sohmer.

[Whereupon Dr. Koomen then presented his prepared paper, supplemented with the use of slides; followed by a slide presentation on the laboratory operation by Mrs. Mildred A. Kerbaugh, Chief, Laboratory Section.]

(The paper by Dr. Koomen and Mrs. Kerbaugh, submitted to the *North Carolina Medical Journal* for possible publication.)

CHAIRMAN SOHMER: The next speaker is Mr. William F. Henderson. Mr. Henderson is the Director of the Program on Access to Health Care.

He's a graduate of the University of North Carolina. He was formerly the Executive Secretary of the North Carolina Medical Care Commission until he retired—and I put that word retired in quotes—in 1973. Subsequently, he has commenced a career in health care systems as a consultant.

Presently, he is a full time consultant. Three private North Carolina foundations—the Duke Endowment, the Kate Bitting Reynolds Health Care Trust and the Z. Smith Reynolds Foundation—both of the latter are in Winston-Salem, are developing support projects showing potential for increasing access to health care in North Carolina.

MR. WILLIAM F. HENDERSON [Director, Program on Access to Health Care]:

(Mr. Henderson's paper submitted to the *North Carolina Medical Journal* for possible publication.)

CHAIRMAN SOHMER: It's with pleasure now that I bring to you a person whom again I really feel needs no introduction to those of you who have been here before.

If any of you have seen this man, you never forget him!

George Conomikes is President of Conomikes Associates, a medical management consultant firm and they work with medical practices of all types from solo to large groups throughout the United States.

They're headquartered in California and regional offices in Atlanta, Georgia and Iowa.

Aside from consulting work with hundreds of physicians, their organization of professionals has undertaken workshops on practice management for medical societies, the American Academy of Family Practice, the American Society of Internal Medicine, the Ob.Gyn., Ophthalmology, Orthopaedic Surgeons, Otorhinolaryngology, the AMA and a variety of groups.

They've developed a workshop for senior residents entitled, "Establishing Yourself in Medical Practice," which is sponsored by the AMA and the state medical societies and has received good press.

He's a featured columnist for national publications; the Internal Medicine News, Family Practice, Ob.Gyn., Pediatrics, Skin and Allergy, Orthopaedic, Ophthalmology, and the Mississippi State Medical Society.

This gentleman, of course, has lots of activities and the enthusiasm with which he will address you on his Time Management for Physicians will explain how he is able to do all of this.

MR. GEORGE S. CONOMIKES [President, Conomikes Associates, Inc., Marina Del Rey, California]: I'm particularly proud to be invited back to North Carolina. We have many friends here.

As a matter of fact, we did an analysis of our business on January 31st and we found out our organization did more work in the State of North Carolina than we did in any other state in the United States. We have a lot of friends here.

(Mr. Conomikes address submitted to the *North Carolina Medical Journal* for possible publication.)

CHAIRMAN SOHMER: We will resume the Third General Session. So, it's with a great deal of pleasure that I ask Dr. Frank Reynolds to introduce our next speaker!

IMMEDIATE PAST PRESIDENT REYNOLDS: It

really is a distinct pleasure for me to introduce to you our next speaker.

Dr. Malcolm Todd is a native of Illinois. He had his medical training in the Chicago area, surgical training there; then after serving in the army he moved to Long Beach, California where he has been practicing surgery, general surgery for over 25 years.

He has been actively working in organized medicine now for well over twenty years.

He served as President of the California Medical Association; he was a delegate to the AMA for over fifteen years; he was President-elect, elected President-elect two years ago and since last June, has been serving as President of the AMA.

During the last two years, he has travelled over 36,000 miles a month telling the story of organized medicine and speaking for you and myself.

He has been to 48 out of the 50 states.

He is a hard-working, dedicated physician. He really has been one of the best spokesman for the AMA that we have ever had.

He's got a tremendous amount of energy and he speaks well and it's a distinct privilege for me to introduce to you Dr. "Mac" Todd, President of the American Medical Association.

[The entire assemblage accorded President Todd a standing ovation as he approached the podium.]

DR. MALCOLM C. TODD [President, American Medical Association]: Thank you, very much. I appreciate those kind remarks, Frank.

(Dr. Todd's remarks submitted to the *North Carolina Medical Journal* for possible publication.)

The door is really open and we shall give you the leadership that you want and that you expect, if you give us this opportunity. Thank you, very much.

[Whereupon AMA President Todd was again accorded a standing ovation.]

CHAIRMAN SOHMER: Dr. Todd, thank you so very much for a most illuminating explanation of the AMA. I have one regret and that is that he can't go home with us to each of the county medical societies and make the same learned presentation.

I think it would have a tremendous influence on our activities in North Carolina. We need to do that now as individuals as he has pointed out.

It gives me a great deal of pleasure now that I give you your President, Dr. James E. Davis!

[Newly elected President James E. Davis was accorded a standing ovation as he approached the podium.]

PRESIDENT DAVIS: It is truly with a deep sense of humility and gratitude that I express to this Society my appreciation for the privilege of serving as your President and the opportunity of addressing you, this morning of course, for the first time.

I do want to express our thanks again to Dr. and Mrs. Todd who came with us, to thank him not only for the very inspiring and informative address and his talk to the House of Delegates yesterday, for his conference this morning with the officers of the Society and the North Carolina AMA Delegation, but for all the help that he and Mrs. Todd have been to us during this visit.

Whereupon President Davis then presented his Presidential Address which was printed in the *North Carolina Medical Journal* Vol. 36, No. 8, August, 1975, page 471. Following his address he was again accorded a standing ovation.]

CHAIRMAN SOHMER: That's a hard act to follow!

The leadership is here. It's up to the Indians now to respond!

[The meeting adjourned sine die at twelve-twenty o'clock.]

President's Dinner

May 3, 1975

The President's Dinner at the 121st Annual Meeting of the North Carolina Medical Society convened, following invocation by Dr. John Glasson, Past President of the Medical Society, and dinner, at nine-twenty-five o'clock, in the Main Dining Room of The Pinehurst Hotel, Pinehurst, North Carolina, Dr. Charles W. Styron, Past President of the Medical Society, acting as Master of Ceremonies.

MASTER OF CEREMONIES STYRON: Mr. President, Ladies and Gentlemen: Welcome to the President's Dinner!

I would like to take this opportunity now to introduce to you those at the head table. I will ask you to withhold your applause until all are introduced.

First, Mrs. Malcolm Todd and Dr. Malcolm Todd, President of the AMA!

Next, Nell Hooper and Dr. Joseph Hooper, presenter of the Jewel!

Mrs. Margaret Davis, wife of the President-elect and Dr. James Davis, President-elect!

Mrs. Lou Russell and Dr. Philip Russell! Mrs. Lou Russell is Auxiliary President!

Ella Glasson and John Glasson!

Marguerite Reynolds and our esteemed President, Frank Reynolds!

(As the Master of Ceremonies introduced each person, they stood to be recognized and all were applauded by the audience at the conclusion of the introductions.)

Now, ladies and gentlemen, since this festive occasion is called the President's Dinner, it seems appropriate that the topic for the evening should be called as follows: "The President: His Strengths and His Weaknesses, If Any!"

My investigation of Frank Reynolds, the man, and Frank Reynolds, the President, has revealed more to me about him than anybody needs to know!

For those of you who do care, the information I have obtained will be the subject of a biography available next year! In paperback!

We have been fortunate this year in having a President whose wife, with her wit and beauty and ability has been a signal advantage for the Medical Society and Frank himself, a man of charm, humor, character, integrity, energy and warm personality, and if I may say, a man with a great sense of fiscal responsibility.

I have been informed by Tilghman Herring, Chairman of the Committee on Finance, that Frank Reynolds' budget for the Medical Society this year cost no more than the cheapest battleship!

And, only slightly in excess of John McCain's budget for the Committee on Public Relations!

And, that the total cost to our membership barely exceeds the budget of HEW—...—including PSRO!

I hope you will agree with me that such a record speaks for itself.

In addition to these above attributes, Frank Reynolds has shown the unique ability to examine all activities of the Medical Society in minute detail and to act on his findings with decision and dispatch and I have proof of this.

Recently, after an election by the Editorial Board of the Journal, Bill Hilliard, Executive Director, and I sent

out a letter announcing a meeting of the Editorial Board at seven-thirty a.m. May 4, 1975, tomorrow morning that is.

Frank sent his copy of the letter to me with the following notation:

Dr. Charles: Congratulations!

Why would a stupid (.....); like you call a meeting at seven-thirty a.m. the morning after the President's Ball? You'll probably feel so bad, you'll be lucky to get there by ten-thirty!

Signed: Frank.

I trust that you will forgive the language but I hasten to remind you that these are his words, not mine!

Finally, I think the fact is established that Frank has two great loves. I think we made this observation of him in the past year.

The first, fine whiskey!

And, the second, beautiful and lovely women!

I have observed that in the twilight of his youth, he drinks the former and talks about the latter.

As a gesture of appreciation for these two great people, Marguerite and Frank, let's all stand and give them a rousing round of applause.

[Whereupon the entire assemblage accorded Dr. and Mrs. Frank R. Reynolds a standing ovation.]

It is now my happy duty to call on our President, Dr. Frank Reynolds, for the installation of officers.

PRESIDENT REYNOLDS: Thank you.

The only trouble that I could see with this ceremony is that nobody introduced the Master of Ceremonies and at this time I would like to introduce my "ex-friend," Dr. Charles Styron!

He said that any remarks I had tonight would have to be very short and I told him I had one sentence—How sweet it is!

At this time, I would like to introduce to you my son and daughter-in-law who are here with me, Keith and Frank Junior. Would you stand up!

[Whereupon Mr. and Mrs. Frank Reynolds Jr. stood up to be recognized.]

I've really been a lot more active. Last year, I had my other three children here and they couldn't get here, so I made them come tonight!

The only other thing I was going to say before I swore in the new officers—there wasn't any doubt a year ago that I would be here tonight, but I didn't know whether all of you might know that I did have a stomach ulcer and about a week after I was sworn in last year, my good friend, Joe Hooper, invited me to go on a fishing trip out to the Gulf Stream, they were having some sort of tournament or something off of Wrightsville Beach.

The wind must have been blowing about thirty knots and we got on this boat that did about eight knots and we got on it about nine o'clock at night so we just tossed and tumbled and everything. I've never had such a trip.

We were about sixty miles off of Wrightsville Beach and finally about ten o'clock the next night, we got back and I was ready to kiss the ground and pray and everything else.

But anyway, to make a long story short, the next day my ulcer flared up so I had a couple of pints of blood was in the hospital, this, that and the other and there was never any doubt at this time last year that I would be here for this ceremony tonight, but there was a lot of doubt whether my stomach could be here, but, fortunately, we're both here!

At this time I would like to ask our new Officers if they would come up so we can swear them in.

Unfortunately, our First Vice President, Dr. John L. McCain and our Second Vice President, Dr. T. Reginald Harris could not be here. Both are very active in the American Society of Internal Medicine and they are meeting in Washington, having their annual meeting so both of them are up there.

But, I would like to ask the Speaker of the House, Dr. Chalmers Carr; Vice Speaker, Dr. Henry Carr; and our President-elect, Dr. Jesse Caldwell, if they would come forward please.

PRESIDENT REYNOLDS: If you'll stand right here in front of me it will be fine. There are only three of you, I think.

[Whereupon the named officers then came forward to the front of the podium for the purpose of installation.]

Now, if you will repeat after me!

I SOLEMNLY SWEAR THAT I WILL CARRY OUT THE DUTIES OF MY OFFICE TO THE BEST OF MY ABILITY. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES OF AMERICA AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL OF MY FELLOW AMERICANS.

What say you?

[Whereupon the newly elected Officers of the Medical Society responded to the oath with, "I do" in unison.]

I declare you duly sworn in!

Now, I've waited a whole year for this! I'd like to ask Dr. James E. Davis if he would stand next to me, please.

[Whereupon Dr. Davis came up to the podium, while President Reynolds administered the oath of office, which Dr. Davis duly repeated.]

I, JAMES E. DAVIS, SOLEMNLY SWEAR THAT I SHALL CARRY OUT THE DUTIES OF THE OFFICE OF PRESIDENT OF THE NORTH CAROLINA MEDICAL SOCIETY TO THE BEST OF MY ABILITY. I SHALL STRIVE CONSTANTLY TO MAINTAIN THE ETHICS OF THE MEDICAL PROFESSION AND TO PROMOTE THE PUBLIC HEALTH AND WELFARE. I SHALL DEDICATE MYSELF AND MY OFFICE TO IMPROVING THE HEALTH STANDARDS OF THE AMERICAN PEOPLE AND TO THE TASK OF BRINGING INCREASINGLY IMPROVED MEDICAL CARE WITHIN THE REACH OF EVERY CITIZEN. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY AT ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL OF MY FELLOW AMERICANS.

TICE AND FREEDOM FOR ALL OF MY FELLOW AMERICANS.

I DO SOLEMNLY SWEAR THAT I SHALL DISCHARGE THE DUTIES OF OFFICE TO THE BEST OF MY ABILITY, SO HELP ME GOD.

What say you?

PRESIDENT DAVIS: I do!

PAST PRESIDENT REYNOLDS: I sure was scared he was going to say, "I don't!"

As my last official act, I would like to give Dr. James Davis my package of Roloids and my package of Titralac!

[Whereupon Dr. Reynolds then presented the two packages of antacid to President Davis.] [Laughter] [Applause]

PRESIDENT DAVIS: Thank you! I'll need them!

CHAIRMAN STYRON: I shall now call on Dr. Joseph W. Hooper, Jr. M.D. of Wilmington, urologist, New Hanover politician, and Past President of the Board of Medical Examiners, to present the President's Jewel.

DR. JOSEPH W. HOOPER: You know it's with a sense of sadness that I'm up here tonight because the man who should be here is a friend who's known to all of us, Donald Koonce, is critically ill in Wilmington. It's my privilege to substitute for him.

Donald and Frank and I kind of grew up together, although both of them are a little older than I am!

Donald kind of raised Frank and myself, in part. He always delighted in telling the story when he was a resident at the James Walker Hospital.

I was twelve years old and had acute appendix and he put me to sleep, he said the greatest mistake he made was "I let that little fella wake up!"

I went by to see him the other day, Thursday morning and I said, "Donald, is there anything you want me to say to Frank Saturday night?" and I got the answer you would expect.

He said, "Say anything you want to, but don't compliment him too much!"

I talked to Frank the early part of the week. I said, "Frank, is there anything you would like me to say?"

He said, "Not a thing. I want you to make it real brief! I don't want any cheese, I just want to get out of that trap!"

Well, Frank's out of that trap now, but anyone who has worked with Frank and many of us have in the last two years, as President-elect and as President, can testify to the sacrifices he's made and the condition of the North Carolina Medical Society is solid testimony to his dedication to his job, the sacrifices he has made.

I would be remiss at this time if I didn't recognize Marguerite and the sacrifices and contributions she has made, because it couldn't have been done without the two of them working together.

All of us in organized medicine in North Carolina today owe a real vote of thanks to Frank Reynolds and Marguerite.

At this time it is my distinct pleasure to pin on Frank, on the immediate Past President, the President's Jewel.

[Whereupon Dr. Hooper then placed the President's Jewel in the lapel of Past President Reynolds.] [Applause]

CHAIRMAN STYRON: Mrs. Davis, would you pin this new badge to our new President before he makes his acceptance remarks.

[Whereupon Mrs. Davis then attached the orange ribbon of President to the name tag of President Davis.]

We shall now hear the acceptance remarks of James E. Davis, M.D. our new President.

[The entire assemblage then accorded President Davis a standing ovation.]

PRESIDENT DAVIS: Thank you, Dr. Styron.

I find my first official duty very pleasant and I'm sure that that won't last, but I do want to add my thanks to Frank Reynolds for the very outstanding job that he has done this year and to tell him how very much I have enjoyed serving with him, as President-elect, and how much I have learned from him about what this Society does and, hopefully, how it functions.

Frank, it has been a real pleasure. We are all deeply indebted to you.

I think all of you have met my most valuable possession, my wife, Margaret, and so now we would like to present to you our most cherished possession, our three sons all of whom are here tonight and I'll ask them to stand up.

The eldest is Jim who is a practicing attorney in Raleigh. Certainly, every doctor needs a lawyer in the family these days and, Jesse, certainly every President needs a lawyer in the family so I'm very thankful that you're also going to be equally blessed with a legal son.

My second son is Ken who is pursuing graduate work in business administration in Phoenix.

And, our third son, George, who is in business in Durham.

We'd like also for you to meet our mother, Mrs. Kenneth Royal from Raleigh.

Our sister and brother, Julia and Kenneth Royal!

And, my very tolerant and long-suffering associate and his wife, Betty and Walter Loehr!

(Each family member stood to be recognized when introduced by Dr. Davis, as did his partner and his partner's wife, all receiving applause of recognition from the audience.)

I do want to thank the Society very much for the honor that you have paid me in allowing me to assume this office, fully realizing that you do not need and you're not seeking an honoree, but truly a worker in the coming year and, hopefully, a leader.

I want to thank the Nominating Committee and the House of Delegates for the fellow officers that you have given me to work with me.

I'm delighted that they were elected. I wish they'd stayed around a little bit longer though to see if we couldn't work together a little better.

Medicine does have many problems as you all know and we will discuss these tomorrow morning; certainly, this is no time to discuss them.

I want to express our especial appreciation to Dr. and Mrs. Todd for being with us today and tomorrow and remind all of you that Dr. Todd will address the Society at eleven o'clock tomorrow morning in the Cardinal Ballroom.

This meeting is now not adjourned, but we will transfer our activities to the Cardinal Ballroom and Freddie Lee the maestro will preside.

Thank you.

[The meeting adjourned at nine-fifty o'clock.]

MEDICAL AWARDS

Moore County Medical Society Medal

In 1927 the Moore County Medical Society established a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to complete.

Each Section Chairman selected a committee of three to decide on the best paper in their section. The winning papers are then turned over to the State Committee, who select the one to receive the medal. The following award was made:

- 1971—Herbert J. Proctor, M.D., Chapel Hill
 "POST TRAUMATIC PULMONARY INSUFFICIENCY"
 (Section on Surgery, May 17, 1971)
- 1972—Donald C. Mullen, M.D., Charlotte
 "CURRENT CONCEPTS IN THE MANAGEMENT OF ABDOMINAL AORTIC ANEURYSMS."
 (Section on Surgery, May 23, 1972)
- 1973—Susan C. Dees, M.D., Durham
 "THE ROLE OF GASTRO-ESOPHAGEAL REFLUX IN NOCTURNAL ASTHMA IN CHILDREN"
 (Section on Pediatrics, May 22, 1973, Pinehurst)
- 1974—Herman Grossman, M.D., Durham
 "PEDIATRIC UROLOGICAL ROENTGENOLOGY"
 (Section on Pediatrics, May 20, 1974)

The George Marion Cooper Award

The Fellows of the Wake County Medical Society present the George Marion Cooper Award established in honor of George Marion Cooper, physician and health benefactor.

The medal is awarded by the Fellows of the Wake County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advancement of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medical Society of the State of North Carolina. The following award was made:

- 1971—Takey Crist, M.D., Chapel Hill
 "ABORTION—WHERE HAVE WE BEEN?
 WHERE ARE WE GOING?"
 (Section on General Practice of Medicine, May 18, 1971)
- 1972—John L. McCain, M.D., Wilson
 "TRAIN YOUR OWN ASSISTANT"
 (Section on Internal Medicine, May 23, 1972)
- 1973—Elizabeth Kanof, M.D., Raleigh
 "SKIN CANCER — EDUCATION AND DETECTION AT A STATE FAIR"
 (Section on Dermatology—May 20, 1973, Pinehurst)
- 1974—William G. Conley, III, M.D., Chapel Hill
 "URINARY TRACT INFECTION IN CHILDREN"
 (Section on Pediatrics, May 20, 1974)

HISTORICAL DATA

In the interest of economy the lengthy Historical Data printed in the Transactions will only be printed periodically. Only the information relating to recent years is included here. Should any member desire additional Historical Data, he

may request the information for earlier years from the Medical Society Headquarters Office at 222 North Person Street, (Mail address: P. O. Box 27167) Raleigh, North Carolina 27611.

HISTORY OF THE NORTH CAROLINA MEDICAL SOCIETY ANNUAL MEETINGS

Date	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	Sec.-Treas.	Members on Roll	Honorary Members	Life Members
1945	No meeting because of O.D.T. restrictions		Paul F. Whitaker.....	Oren Moore.....	Wm. H. Smith Zack D. Owens.....	Roscoe D. McMillan...	1,811	7	383
92 1946	Pinehurst.....	889	†Oren Moore.....		Wm. H. Smith Zack D. Owens.....	Roscoe D. McMillan...	1,939	6	397
93 1947	Virginia Beach, Va.....	444	†Wm. M. Coppridge....	Frank A. Sharpe.....	G. E. Bell J. B. Bullitt.....	Roscoe D. McMillan...	2,191	7	404
94 1948	Pinehurst.....	920	†Frank A. Sharpe(†)....	James F. Robertson...	V. K. Hart J. G. Raby.....	Roscoe D. McMillan...	2,298	8	407
95 1949	Pinehurst.....	998	†James F. Robertson...	G. Westbrook Murphy	Joseph J. Combs Joseph A. Elliott....	Roscoe D. McMillan...	2,318	5	405
96 1950	Pinehurst.....	947	†G. Westbrook Murphy	Roscoe D. McMillan...	Ben F. Royal Joseph A. Elliott....	Millard D. Hill.....	2,283	5	455
97 1951	Pinehurst.....	938	Roscoe D. McMillan...	Frederic C. Hubbard...	Joseph A. Elliott.... Henderson Irwin....	Millard D. Hill.....	2,341	5	469
98 1952	Pinehurst.....	969	Frederic C. Hubbard...	J. Street Brewer.....	Forest M. Houser Arthur Daughtridge..	Millard D. Hill.....	2,326	5	476
99 1953	Pinehurst.....	1,016	J. Street Brewer.....	Joseph A. Elliott.....	George W. Paschal, Jr. John R. Bender.....	Millard D. Hill.....	2,673	5	486
100 1954	Pinehurst.....	1,077	†Joseph A. Elliott.....	Zack D. Owens.....	John F. Foster Julian A. Moore.....	Millard D. Hill.....	2,801	6	486
101 1955	Pinehurst.....	991	Zack D. Owens.....	J. P. Rousseau.....	George W. Paschal, Jr. E. W. Schoenheit....	Millard D. Hill.....	2,896	6	507
102 1956	Pinehurst.....	1,022	†James P. Rousseau....	Donald B. Koonce.....	E. W. Schoenheit.... Milton S. Clark.....	Millard D. Hill.....	3,058	7	561
103 1957	Asheville.....	867	†Donald B. Koonce.....	Edward W. Schoenheit	John S. Rhodes O. Norris Smith....	Millard D. Hill.....	3,127	8	522
104 1958	Asheville.....	781	Edw. W. Schoenheit...	Lenox D. Baker.....	George W. Holmes Amos N. Johnson....	Millard D. Hill.....	3,171	9	542
105 1959	Asheville.....	651	Lenox D. Baker.....	John C. Reece.....	Amos N. Johnson.... Kenneth B. Geddie...	John S. Rhodes.....	3,211	10	251
106 1960	Raleigh.....	848	John C. Reece.....	Amos N. Johnson....	Chas. M. Norfleet, Jr. W. Walton Kitchin...	John S. Rhodes.....	3,247	12	472
107 1961	Asheville.....	636	†Amos N. Johnson....	Claude B. Squires....	Theodore S. Raiford. Charles T. Wilkinson	John S. Rhodes.....	3,248	12	438
108 1962	Raleigh.....	745	†Claude B. Squires....	John R. Kernodle....	John A. Payne, III J. Sam Holbrook....	John S. Rhodes.....	3,339	9	425
109 1963	Asheville.....	714	John R. Kernodle....	John S. Rhodes.....	H. Fleming Fuller Jacob H. Shuford....	Charles W. Styron....	3,491	9	431
110 1964	Greensboro.....	677	John S. Rhodes.....	T. S. Raiford.....	Wm. F. Hollister F. G. Patterson....	Charles W. Styron....	3,473	8	398
111 1965	Charlotte.....	738	†T. S. Raiford.....	George W. Paschal, Jr.	Hubert McN. Potent. Wayne J. Benton....	Charles W. Styron....	3,516	8	390
112 1966	Asheville.....	545	George W. Paschal, Jr.	Frank W. Jones.....	W. Otis Duck John L. McCain.....	Charles W. Styron....	3,597	12	339
113 1967	Pinehurst.....	644	†Frank W. Jones.....	Robert A. Ross.....	David G. Welton Daniel A. McLaurin...	Charles W. Styron....	3,606	14	302
114 1968	Pinehurst.....	623	†Robert A. Ross.....	David G. Welton.....	E. T. Beddingfield, Jr. James S. Raper.....	Charles W. Styron....	3,642	13	298
115 1969	Pinehurst.....	577	David G. Welton.....	Edgar T. Beddingfield, Jr.	John Glasson Mark McD. Lindsey...	Charles W. Styron....	3,674	13	298
116 1970	Pinehurst.....	580	Edgar T. Beddingfield, Jr.	Louis deS. Shaffner...	Robert P. Crouch Rose Pully.....	Charles W. Styron....	3,711	14	289
117 1971	Pinehurst.....	575	Louis deS. Shaffner...	Charles W. Styron....	George G. Gilbert James G. Jones.....	E. Harvey Estes, Jr..	3,765	14	287
118 1972	Pinehurst.....	543	Charles W. Styron.....	John Glasson.....	Kenneth E. Cosgrove William H. Romm....	E. Harvey Estes, Jr..	4,059	15	267
119 1973	Pinehurst.....	562	John Glasson.....	George G. Gilbert....	Frank R. Reynolds... Harry H. Summerlin..	E. Harvey Estes, Jr..	4,123	15	278
120 1974	Pinehurst.....	623	George G. Gilbert....	Frank R. Reynolds...	*Michael F. Keleher D. E. Ward, Jr.....	E. Harvey Estes, Jr..	4,294	15	283
121 1975	Pinehurst.....	637	Frank R. Reynolds...	James E. Davis.....	Jack Hughes M. Frank Sohmer....	E. Harvey Estes, Jr..	4,598	14	303

†) Deceased.

‡) Died during term of office; succeeded by James F. Robertson, president-elect.

*) Resigned as First Vice-President.

†) Became First Vice-President at resignation of Dr. Keleher.

**ROSTER OF MEMBERS OF COMMISSION FOR HEALTH SERVICES
(Formerly State Board of Health)**

Name	Address	Appointed by	Term
James S. Raper, M.D.	Asheville	Medical Society	1967 to 1971
Paul F. Maness, M.D.	Burlington	Medical Society	1967 to 1971
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Dan Moore	1967 to 1971
Ernest A. Randleman, Jr., PhG.	Mount Airy	Gov. Dan Moore	1967 to 1971
Joseph S. Hiatt, Jr., M.D.	Southern Pines	Medical Society	1969 to 1973
Jesse H. Meredith, M.D.	Winston-Salem	Medical Society	1969 to 1973
Lenox D. Baker, M.D. (1)	Durham	Gov. Robert W. Scott	1969 to 1973
J. M. Lackey	Hiddenite	Gov. Robert W. Scott	1969 to 1973
Charles Barker, D.D.S.	New Bern	Gov. Robert W. Scott	1969 to 1973
Ralph W. Coonrad, M.D. (2)	Durham	Gov. Robert W. Scott	1971 to 1973
James S. Raper, M.D.	Asheville	Medical Society	1971 to 1975
Paul F. Maness, M.D.	Burlington	Medical Society	1971 to 1975
Ernest R. Randleman, Jr., PhG.	Mount Airy	Governor Robert W. Scott	1971 to 1975
Donald W. Lackey, D.V.M.	Lenoir	Governor Robert W. Scott	1971 to 1975
Jesse H. Meredith, M.D.	Winston-Salem	Medical Society	1973 to 1977
Maurice A. Kamp, M.D.	Charlotte	Medical Society	1973 to 1977
Richard T. Belton, D.D.S.	Gastonia	Gov. James E. Holshouser, Jr.	1973 to 1977
Faye B. Eagles, D.C.	Rocky Mount	Gov. James E. Holshouser, Jr.	1973 to 1977
Grady Hunter	Boonville	Gov. James E. Holshouser, Jr.	1973 to 1977
Buford W. Kidd, O.D.	Greensboro	Gov. James E. Holshouser, Jr.	1973 to 1977
Clyde W. Kiker	Greensboro	Gov. James E. Holshouser, Jr.	1973 to 1977
Paul F. Maness, M.D.	Burlington	Medical Society	1975 to 1979
William D. Rippy, M.D.	Burlington	Medical Society	1975 to 1979

(1) Resigned when appointed Secretary, Department of Human Resources.

(2) Fill unexpired term Dr. Baker.

ROSTER OF MEMBERS OF BOARDS OF MEDICAL EXAMINERS

Name	Address	Term
Bryant L. Galusha, M.D., President	Charlotte	1968 to 1974
Charles B. Wilkerson, Jr., M.D., Secretary	Raleigh	1972 to 1978
Frank Edmondson, Jr., M.D.	Asheboro	1970 to 1976
Joseph W. Hooper, Jr., M.D.	Wilmington	1968 to 1974
Cornelius T. Partrick, M.D.	Washington	1968 to 1974
E. Wilson Staub, M.D.	Pinehurst	1972 to 1978
Vernon W. Taylor, Jr., M.D.	Elkin	1970 to 1976
*Joseph J. Combs, M.D., Executive Secretary	Raleigh	
David S. Citron, M.D.	Charlotte	1974 to 1980
James Jerome Pence, M.D.	Wilmington	1974 to 1980
Jack Powell, M.D. (1)	Asheville	1974 to 1980
Bryant L. Galusha, M.D. (2)	Charlotte	1974 to 1980
Bryant D. Paris, Jr., Executive Secretary	Raleigh	1973 to —

* Retired October 31, 1973

(1) Resigned

(2) Fill term Dr. Powell

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